			1 ⇒ For Stata Registrar	State of Mary		artment of F		nd Mental Hy	giene 2	006 500
			Decedent's Nâme (First, Middle,	ast)				2. Date of De		3. Time of Death
	Physic		RESSIE	NADARZYI	NEKI			Month	Day	2006 11:20 H M
5	/Medi Exami		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of			ty of Death
1			HARBOR HOS	PITAL CE	NTER	BAL	TIMO	DRE	N/	A
	Funeral			. Sex 7. Age (In	yrs. last birthday,					9. Birthplace (State or Foreign
	Director		215-22-6349	1□M 3,EF 87	Yrs.	Widnitis Days	nours	May 28	7 1918	North Carclina
	and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Manyi f eho	5				oution.				1 ☐ Yes 2 ☐ No
	15e.7	ect	Maryland N/A 10e. Street and Number	D.S.	altimore	10f, Zip Code			10s Citizen e	f What Country?
	Sa or		3602 7th Street				.225		USA.	what Country?
	death me 2;	era	11. Marital Status	12. Was Decedent Ever	in U.S. 13.			n? (Specify Yes or No		ace - American Indian,
21215-0036	within 72 hours after death with the Maryland ane, "naturel", or iteme 23a or 28a-1 show he Medical Examiner mart be rutified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cub. 1 ☐ Yes 2 ☑ No		n? (Specify Yes or No Puerto Rican, etc.)	Spec	ack, White, etc.
Ö	2 ho	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of	Business/Industry
218	hin 7	e d	(Specify only highest of Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most (d)	of working		
	Hygien Hygien ther th	Š	12		Test	Technici	an		West	inghouse
p	be file tal Hy doth	Be (17. Father's Name (First, Middle, La					s Name (First, Middle	, Maiden Suma	
<u>yla</u>	Ment Ment arked	2	Allen	Jerome	Cox		Cc	rnelia		Oakley
Maryland	ss 1 and 2 should be filed within 7 of Health and Mental Hygiene. Ifem 27 is marked other then "n rother treumatic event, the Madi		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number	or Rural Route Numb	er, City or Tow	n, State, Zip Code)
	and ealth m 27		Bobby Lee Mannir				Road,	Berlin, M	21811	
ore	ges 1 t of H if ite		20a. Method of Disposition 1 □ Burial 2 🖫 Cremation 3		Db. Place of Dispo	sition (Name of Oracle)	(9)	Date		- City or Town, State
Ë	Pages ment of P ent: If its ury or of		4 □ Donation 5 □ Other (Spec	16.1	a Loudan	Danle	Ma			more, Maryland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service		2	2. Name and Addre		Loudon Pa		
=	40 E E G							re., Balti		D 21229
>	Physician /Medical	87	23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Finat disease or condition resulting in death)	-0.	CEST (Consequence of):	E HE	ART	FALUR		Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	CHRO	NIC	RENAI	LI	AILURE	=	>2 YEARS
-	P #	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con						
	ecute end -tran	Examin	that initiated events resulting in death) Last	a. ACUT		ENAL	- +	ALLUR	E	14WEEKS
8760,	cate be executed physicien end the burial-transit			Due to (or as a con	UMOL	VA				> 2WEEKS
387	physis the	dicai	•	Ld	OMIGA) (FT				/ WEE/C
O. Box 6	that the death certificated by the attending plant of detached for use as t	by Physician/Me	lF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ R 4 ☐ Pregnant at time 9 ☐ Unknown	etat death 3	Ectopic pregnancy Other (specify)	1			ate of delivery lonth Day Year
9	thet sed by deta	4 7	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use cor	ntribute to the cause of death?
ords	law requires thet as been signed by 2 should be deta	eted b		TENSION				_ 10	Yes 2 No	3 Probably 4 Unknown
Division of Vital Records, P.	The ete h page	Completed						24a. Was auto perfo 1 Yes	osy omed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
<u> </u>	Physicien: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hamitali				f Death (Check only o	one)	
ō	Phys this al dii	2	1 Yes 2 No	Annual Contract of the Contrac	2 ER/Outpatien	-	4 🗆 Nurs	ing Home 5 ☐ Resi		
5	After fune	Certification:	1 SMatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury	28c. Injun World		28d. Describe	how injury occu	rred
Si	r Attending er death. rector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not	0.0	14.6		Yes 2 □ No			
S	or A after Dire	E E	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)	eet, factory, office		28f. Location (Street and Num vn, State)	ber or Rural Route Number,
	spira ours neral filled		29a. Certifier 1 Certifying F	hydrians To the best of the	broughton tool	Committee of the Arm		1		
	P Fur	edical	(Check only 2 Medical Exa	hysicians To the best of my miner: On the basis of exam and manner stated.	nination and/or in	estigation, in my of	pinion, death	occurred at the time,	date and place.	anner as stated. , and due to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	We .	29b. Signature and title of certifier			29c. License	e number		29d. Date sign	ed (Month, Day, Year)
	3		ARD. MAAL	Piladie		RIC	001		•	
9	8	1	30. Name and address of person who	completed cause of death (Item 23a) (Type				11/44 7	2006.
	1		ABDUL ADJEI				TREET	- PALTIN	ORRE	MARYLAND 21225
	Sta		31. Date filed (Month, Day, Year)	32 Aegistrar's Si	gnature	W =	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,110114	re poe,	
	Registra	ar	MAY 1 2 21	32 Aegistrar's Si	S. Ag	sur!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Olga Barbara Petrush May 2006 6:26 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Campus Bel Air Harkord If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 16,1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Days 1 M 2 √F Hours Months 212-14-0911 86 Yrs. Director Maruland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural, or Itema 23a or 28e-f show eny Injury or other traumatic event, Ita Madical Examiner must be notified at once. 1 XYes 2 □ No Directo N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3005 Woodring Avenue 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Specify: ģ 3 ☑ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fund Mental 1 Benda James Barbara Klima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Petrush 9400 Perglen Road, Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Cemetery 5/15/2006 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cona Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day signed by the a d be detached for 4□Pregnant at time of death 5 Other (specify) _ 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner: cancer 2 No Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

2etrush, 01 as #800451,

State Registrar

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Thomicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be

MAY 1 2 2006

determined

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral C

and manner stated.

eatman 50011

e and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tes 2 No

21338

pper Chesapeake

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

247.11.2006

			For State Registrer	State of Ma	ryland	•	artmen			and M	-	giene Reg. No.	06	15003
	Physici	an	1. Decedent's Name (First, Middle, Las	1							2. Date of De	Day	Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give	estreet and number			4h City	Town or	Location o	of Death	May		oo 6	2340 M
4	Examin	ier		Ind Medical	5.154		13.0 City,	1.	no ru	Deali	,	N/	A	
	Funeral Director		5. Social Security Number 6.56 567-02-1030		(In yrs. last	Yrs.	If Under Months		If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 2	th Year) 948	9. Birthr Cour Mary	olace (State or Foreign ntry) 1and
	land wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						1	Od. Inside City Limits
	Mary -f eh	ţo	MD Anne Art	ındel	Annar	olis								1 ☐ Yes 2 No
	th the	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	23a c	raic	11 A3 Spa Creek I	Landing				1403				Mexic		
36	72 hours after death with the Maryland natural', or iteme 23a or 28e-f ehow oral Examinat must be invitted at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X No If Yes, Give			Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto (cify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ce - Americk, White,	
00	hour tural	ed b	3 Widowed 4 Noivorced 15. Decedent's Ed	Year or Dates:	1	6a. Dece	dent's Usua	I Occupa	tion	whit	e	16b. Kind of E	Whi Business/In	
21215-0036	within ane. than	Completed	(Specify only highest grain Elementary/Secondary (0-12)			(Give life.	kind of wor DO NOT us Ograp	rk done d se retired)	uring most	t of workit	ng	Self E		
	e filed al Hygie other vent, II	BeC	17. Father's Name (First, Middle, Last)				-0-1		18. Mothe	r's Name	(First, Middle	, Maiden Suma	me)	
Maryland	should be that Mental I was marked or umatic eve	To	Francisco A. Poud	cel Santos	_				Anna	a Mar	ia van	der Me	rsch	
Jar	and rand		19a. Informant's Name/Relationship (7	_			-					er, City or Towr		
_	1 and Health em 27	1	Mary Anne Irace -	- Partner	20b. Plac	e of Dispo	sition /Nan	ne of	1		AIIIIap	olis, M		
5	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		1		natory or of emato			May 5	,06	Baltimo	re. M	Maryland
Baltimore ,	permit. F Departm Importar any injui		21. Signature of Funeral Service Licen		1			•			-			nd 21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused to	the death.								Ly Lai.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lasta	10,1	C	ance							Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ice of):								
	Lxummer	<u></u>	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	consequen	ce off.								
18	ted insit	Examiner	cause. Enter Underlying Cause Unsease or injury that initiated events		consequen	100 017.								
0,	sician and burial-transit		resulting in death) Last	Due to (or as a	consequen	ice of):								
8760,	cate be ex physician the buria	icai		d			· -				_			
9	ertifica ling ph e as tl	Med	IF FEMALE:	20 - 1/		-	-012	17-1	0-80					
P.O. Box	The law requires that the death centificate be executed tie has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal de	ath 3	Ectopic pro						ate of deliv onth	ery Day Year
	uires that signed by	by	Part II. Other significant conditions of	ontributing to death bu	t not resultir	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did		tribute to t	he cause of death?
Records,	The faw requir te has been sl age 2 should	Completed											Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available impletion of cause of
Vital		Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only		7	24.10
of <	Physician: this certificatal director, i	2	1 ☐ Yes 2 No	Hospital: 1 Inpatier		/Outpatier		and the same	4 🗀 INU	-		dence 6 🗆 Ot		(y)
on C	ding After fune	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	f 2 M	8c. Injury Work	at ? ′es 2∐l		28d. Describe	how injury occu	rred	
Division	or Attending Ph after death. Director: After th in by the funeral	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		rv - At home	a farm str			65 2 🗆 1		28f. Location /	Street and Num	ber or Rur	al Route Number,
Οİ	al or A after I Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	, ,	, , , ,	,			City or To	wn, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Photographic (Check only one) 2 Medical Example 1	ysician: To the best of iner: On the basis of and manner state	examination	edge, deat n and/or in	h occurred vestigation,	at the tim , in my op	e, date and inion, dea	d place, a	and due to the ed at the time,	cause(s) and n date and place	nanner as s , and due t	stated. o the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier				290	. License	number			29d. Date sign		
•	/		Du 21	Ju An	D		A		76435			5-3	- 2	006
_	12	-	Dw. J Dexto	completed cause of de	/		C	Ba	It, no.	re, M	٠D .	21201		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 2	32. Registra	r's Signature		parti	و						

	1	State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 5 0 0 Certificate of Death Reg. No.
Physician /Medical Examiner		a. Facility Name (If not institution, give street and number) 2. Date of Death Month Day Year H 2006 (1 2014) 4b. City, Town, or Location of Death Ac. County of Death
Funeral Director		Edenton Retirement Community Frederick Frederick S. Social Security Number 213-68-4523
ith the Maryland or 28s-f show be notified at	1	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit 1 Yes 2 N MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any jujury or other traumatic avant, the Medical Examiner must be notified at once. To Be Completed by Euneral Director		State Stat
ed within 72 hours ygiene. Nor than "natural" t, the Medical Ex.	a posidino	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry
should be filed and Mental Hyg a marked other umatic avant.	200	17. Father's Name (First, Middle, Last) Fred Gutman 18. Mother's Name (First, Middle, Maiden Sumame) Bellan Houck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pages 1 and 2 ent of Health a nt: If Item 27 le ry or other trai	-	Sharon Gewehr - Niece 3008 N. Underwood St., Arlington, V222213 20a. Method of Disposition 1 Burial 2 Cremation 3 Bemoval from State 1 Donation 5 Donation
permit. F Departm Importar any injus		21. Squature of Filteral Service Live see 22. Name and Address of Facility Loudon Park Funeral HOme 3620 Wilkins Avenue, Baltimore, MD 21229 23a Raph, Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between
	7	Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.
death certificate be a attending physicial of for use as the but	Physician/Medical Ex	Due to (or as a consequence of): d.
gne be c	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown
	Be Completed	24a. Was an autopsy findings availated autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check on one examiner)
ing Phys	Certification: 10	1 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 4 Nursing Home 5 Residence 6 X ther (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident Specify 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 Yes 2 No
Hospital or 4 hours afte Funeral Dir iely filled in	Medical Certifi	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Location (Street and Number of Rural Route Number, color of Street and Number of Ru
To the within 2 To the complete	Mec	29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Log J. Tall W. W. L. Tolk Gy. Tolk

State of Maryland / Department of Health and Mental Hygiene State Registreend Item #11 PFH C855 5/12/06 ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** RIOPM MAY MOISEY PERELMAN 09 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOR Under 1 Year If Under 24 Hrs. HOSPITAL OF BALTIMORE N/A 8. Date of Birth 0371871940 9. Birthplace (State or Foreign Country) BELORUSSIA 5. Social Security Number **Funeral** Hours 1**∑**M 2□F 218-39-8111 66 Vrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itema 23a or 28a-f ehow rthen "naturel", or itema 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 💯 No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6960 MARSUE DRIVE APT. 1-D 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: WHITE -9 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other then College (1-4or 5+) Elementary/Secondary (0-12) MECHANIC TRACTOR permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygiel Important: if item 27 ie marked other th eny injury or other traumatic event, the 2006. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **PFRELMAN** UNKNOWN YUDFI BRONYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 DEAVEN COURT - BALTIMORE, MD 21209 SOFIYA SHIBANOVA / WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition BAL TIMORE HEBREW 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/11/2006 REISTERSTOWN, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** ERY SISEAJE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ig physicien and as the burial-transit Box 68760. MECITUS, TYPE II Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the e P.O. 9☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed? 1☐ Yes 2☑ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Certification: s effer dea. rei Director: Affe t Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hoepital or Atte within 24 hours efter de: To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mulugeta SINATHOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MOISEY PERELMAN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) P M **Physician** 4:45 May 8, 2006 Riggins Frances /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Baltimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 2121 Parksley Ave Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🕇 F Baltimore Sept. 10, 1919 Director 238-30-2176 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State wore ! r then "natural", or items 23a or 28a-f ehor the Medical Examiner must be natified at 1 Yes 2 No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3609 Clarenell Rd. 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: White 1 Never Married 2 X Married Specify: Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Factory Donut Factory worker 12 th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hattie Denny Ray Moser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2121 Parksley Ave Baltimore Maryland 21230 nt of Health a Ruby Parrott Granddaugther Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Loudon Park Cemetery 05-12-06 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Haltimore City MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudon Park Funeral Home Baltimore Maryland 21229 3620 Wilkens Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death STAGE CHRONIC OBSTUCTIVE TENYEARS Immediate Cause (Final END Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner il or Attanding Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown PULMONALE HYPERTENSION WITH HYPERTENSIVE 24a. Was an autopsy autopsy performed?

- O. A. T. ARILLATION, CARDIOVASCULAR DISENSE performed?
10 yes 2 peno 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ATRIAL FIRRILLATION. 26. Place of Death Check on one 25. Was case referred to medical examiner? Certification: To Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10106 leran D18362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | Kreus Ave. Suite 308 Ballo. Md2/229 3455, Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2006 Registrar

		-	For State Registrar	State of	Maryland		partment ertificate		ealth and Death	Mental H	ygiene Reg. No.	2006	15007
			Decedent's Name (First, Middle, Last))						2. Date of I	Death Day	Yeer	3. Time of Death
	Physicia		Robert Rosenberg							05	1		4:00 A M
	/Medica	al. er	4a. Facility Name (If not institution, give	street-and number	rsev H	all I	Rd .4b. City,	Town, or	Location of Deat	th	4c.	County of Deat	h
			MorningSide House				E11		t City			Howard	
8 ·	Funeral		5. Social Security Number 6. Se	x 7 9 M 2 □ F	. Age (In yrs. I	ast birthd	Months	1 Year Days	If Under 24 Hrs Hours Min	. (Month, i	Day, Yeer)	Co	hplece (State or Foreign untry)
	Director		053-12-2447	3M 2UF	85	Yrs	•			02-1	<u>7–192</u>	1	N.Y.
	pu 🖈 :	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town o	r Location						10d. Inside City Limits
	sho	ঠ		. 3	E3	1	t City						1 ☐ Yes 2 ☐ No
	the N	Director	MD Howar 10e. Street and Number	a	E. I.	LICO	tt. City				10g. Citi	zen of Whet Co	ountry?
	with the or		5330 Dorsey Hall	Dr.			210	42				USA	
	be filed within 72 hours after death with the Maryland and Hygiene. Ital Hygiene. Gother than "natural", or Rems 23a or 28a-f show event, the Macecal Examiner must be notified at swent, the Macecal Examiner must be notified.	Funerai	11. Marital Status	12. Was Deced	lent Ever in U.	S.	13. Was Dece	ent of Hi	spanic Origin? (Specify Yes or	No-	14. Race - Ame Black, Whit	
	r Rer	필	1 ☐ Never Married 2 Married	Armed Ford	2 □ No		1 ☐ Yes	Ϋ́	Specify:	no rican, etc.)		Specify: Whi	
3	al', o	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dat	tes:		1 1 103	2	эрвену.				
	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		10	ecedent's Usua live kind of wo	k done o	during most of wo	orking	16b. Ki	nd of Business	Andustry
4	thin	npfu	Elementary/Secondary (0-12)	College (1-			fe. DO NOT u				C	4-1 Coa	
4	ygier ygier ft, Illi	Co	12 th		4	Soc	ial Sec	urit	y Manag 18. Mother's Na			<u>ial Sec</u> Sumame)	urily
3	ed all all all all all all all all all al	Be	17. Father's Name (First, Middle, Last) Morris Rosenberg						Sarah S				
y	2 should be filed withing and Mental Hygiene. Is marked other there aumatic svent, the Mental Hygiene.	_T	19a. Informant's Name/Relationship (7	ima Printi		19h M	lailing Address	(Street	and Number or F		nber, City o	r Town, State,	Zip Code)
2	12 sh ch and 7 is r traur		Arline Hershey Ro		-Wife	5330	O Dorse	у На	11 Dr.,	Apt. 2	18, E	llicott	City, MD
ָ ט	permit. Pagas 1 and 2 should Department of Health and Mer Important: If item 27 is marks sny injury or other traumatic once.		20a. Method of Disposition		20h F	lace of D	isposition (Na	ne of	val	Date	20c. Lo	cation - City or	Town, State 21042
5	Pages nent of t		1 ☐ Burial 2x☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				re Crem		ÿ@	11-06	Palt:	imore M	aryland
	artme ortan injur		21. Signature of Funeral Service Licen			Pong	on Park 22. Name ar	d Addre	ss of Facility k Funer	ol Uomo			
0	permit. Departr Imports sny inj	0.1		A STATE OF THE PARTY OF THE PAR					ns Ave		re Ma	rvland	21229
	- 8-		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that ca	used the deat	h. Do no	t enter the mod	le of dyin	g, such as cardi	ac or respirator	y arrest,		Interval Between
à	Pnysician		Immediate Cause (Final	Live	CEO	dies	70						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (c	or as a conseq	uence of)							
	Examiner		Conventially list conditions	. Cir	chos	5							1 week
	≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of)	:						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consec	mence of	,						
00,	death certificate be executed e attending physician and id tor use as the burial-transit	E	Tooling in dozin,	00 800	or as a conseq	1001100 01)							
0	physic the b	dicai	•	d									
Ď X O	leath certifical attending phy I for use as th	/Me	IF FEMALE:	23c. If yes, outo	come of pregna	ancy						23d. Date of de	elivery
0	atten tor u	cian	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta ant at time of c		3 ☐Ectopic p 5 ☐ Other (s				_	Month	Day Year
	the d y the	Physician/Med	1 U Yes 2 No 9 Unknown	9□ Unkno	wn								
7	requires that the deben signed by the should be detached	by Pi	Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in t	he underlying	ause giv	en in Part I.	23e. D		N /	to the cause of death?
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CO	law rec as bee	ojete	Diabetic Gas	troph	resis					24a. V	vas an utopsy	24b. Were a	utopsy findings available completion of cause of
T T	o ~ o	Completed								1 Ye	enormed?	death?	s 2 No
Vital	i cian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?							eath (Check or	nly one)	A. Ac	eleted.
01 <	d: is. X	70	1 ☐ Yes 2 No		npatient 2			UA		Home 5 F		6 X Other Isn	ecity LIVIN
	De Te	ation:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Mont	of Injury th, Day Year)	28b. Tir Inj	ury	28c. Inju Wo	rk?	28d. Descr	De How Inju	ry occurred	,
<u> </u>	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At h	ome fem	M etenat (a sto	_	Yes 2 □ No	28f. Locatio	on (Street a	nd Number or F	Rural Route Number,
DIVISION	- H	Certific	4 Homicide determined	288. Flace	ng, etc. (Speci		rr, street, lacto	y, onice		City or	Town, Stat	e)	
_	Hospital 24 hours a Funeral I tely tilled		29a. Certifier 1X Certifying Pr	vsician: To the	best of my kn	owledge,	death occurre	at the ti	me, date and pla	ice, and due to	the cause(s	and manner a	as stated.
	To the Hospital of within 24 hours at To the Funeral D completely tilled in	edical	(Check only 2 Medical Examone)	niner: On the ba	asis of examin ner stated.	ation and	or investigation	n, in my	opinion, death oc	curred at the ti	me, date an	d place, and du	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				25	c. Licen	se number	0	29d. Da	ate signed (Mor	nth, Day, Year)
			Mystions	a MUD				Der	56162	.4	5	1110	0
	6		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (1	vne Print)				NAN	minim	
	٢		Tracy Gutierrez	7070	Som	ue)	Morse	Dr	. Colu	mbia,	IIID	41045	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	5 A.C.	egistrar's Sign	ature 6	scott						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 04/21/2006 Year Ам **Physician** 1:55 Marilyn Landt Richards /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House 8. Date of Birth (Month, Day, Year) 06/24/1939 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2X F Wisconsin 66 Director 390-36-4424 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State r than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Prince Georges Bowie Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20715 4510 Orangewood Lane Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Home Maker permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other It any Injury or other traumatic event, Ita once. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cecilia Tomcheck Oliver Landt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4510 Orangewood Lane Bowie, MD 20715 Robert Richards/ Husband 20b. Place of Disposition (Name of Sacred Heart Catholic Date 20c. Location - City or Town, State 20a. Method of Disposition

2 Cremation 3 Removal from State 04/27/2006 Bowie, MD Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service License 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Be Completed by Physician/Medical be detached for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2X No : After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 □ Nursing Home 5 □ Residence 6 ②Other (Specify) Hospice 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Naturai 5 Pending 1 Tes 2 No investigation death. after death Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a To the Funeral C 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

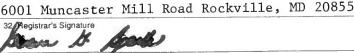
State Registrar

31. Date filed (Month, Day, Year) APR 2 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Joseph Kaplan, M.D.



Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

29c. License number

D35635

29d Date signed (Month, Day, Year)

04/21/2006

			1 - For State Registrar	State of Maryland		irtment of H tificate of I			ene 2006	15009
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Robert HAR)		Y 5	r		2. Date of Death Month	Bay Year 8 2006	3. Time of Death 3.00A M
	Examir Funeral Director		4a. Fecility Name (If not institution, give Shady Grove Adv 5. Social Security Number 578-28-2954	entist Hospita		•	ockville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y September 2	4c. County of Death Mont (ear) 9. Birth Co	
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montg	10c. City	y, Town or Lo		ithersbur			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	eath with th	by Funeral Director	10e. Street and Number 333 Russell A	Avenue #602	C 13 V	10f. Zip Code Vas Decedent of Hi	20877		United	States
9600	within 72 hours after death with the Maryland one. then "neturel; or iteme 23s or 28s-f show the Madical Examiner must be notified at	d by Fun	1 Never Married 21 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII	1	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hyglene. Important: if item 27 is marked other then "naturel; or items 23a or 28a-1 show any njury or other traumatic event, the Modical Examiner must be notified at ADE.	Completed	15. Decedent's Edu (Specify only highest grad Etementary/Secondary (0-12)		(Give	lent's Usual Dccupa kind of work done of DO NOT use retired Man	turing most of work	ing 16	T.W. Perr Building	:y
Maryland	should be fit nd Mental H marked oth matic even	To Be	17. Father's Name (First, Middle, Last) Osca: 19a. Informant's Name/Relationship (Ty	r Harvey Robey		g Address (Street a			niden Sumame) M. Fowler City or Town, State, Z	ip Code)
nore, Ma	ages 1 and 2 nt of Heelth a :: if item 27 is or other trace		Melinda Schillin 20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b. Pl	lace of Dispos	3 Thoreas sition (Name of patory or other place tery	θ)	Date 20	Maryland lc. Location - City or 1	
Baltimore,	permit. Pa Departmen Important any njury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	C	remāto	riim Inc.	May 9	, 2006 ert A. Pi se Inc 20814-350	Bethesda, umphrey Fu 7557 Wisco)1	Maryland neral Home/ nsin Avenue
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complete shock, or heart failure. List only or transdate Cause (Finat disease or condition resulting in death)	incations that caused the death ne cause on each line. PANCYTE Due to (or as a consequ	Denot enter	er the <i>m</i> ode of dying	g, such as cardiac	or respiratory arres	t.	Approximate Interval Between Onset and Death
8760, A	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to or as a conseq	ience of):					
.O. Box 6	death certifi e ettending id for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	·		23d. Date of delin	very Day Year
S, D	The law requires thet the site has been signed by the page 2 should be detached.		Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the un	derlying cause give	on in Part I.	23e. Did toba	cco use contribute to	the cause of death?
al Reco		Completed							prior to c	opsy findings available ompletion of cause of
Division of Vital Record	문문교	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	/-	ER/Outpatient 28b. Time of tnjury	28c. Injury Work	or: 4 🗀 Nursing Ho	h (Check only one) me 5 TResidence 28d. Describe how	ce 6 Other (Specintury occurred	ify)
Divis	To the Hospitel or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	i Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify,	")			City or Town,		
	To the Hos within 24 hc To the Fun completely f	Medical	29a. Certifier (Check only one) 2 Medical Examin 29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	ion and/or inv	29c. License	number	290	and place, and due	
) ==	10+1 Sta	to	ame and address of berson who co	9707 MEDIC	CAL C	Print)	61083		nue I	2006 40 2032
	Registr		MAY 1 2 2006	82. Registrar's Signat	BOOM					

REZNICK

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SHIRLEY

29d. Date signed (Month, Day, Year)

May 10 2006

			1 - State Regist Amend Item #	10f Per FH G85	5 5/1 9	766a5f	of Death	Α	Reg. No.	JUb	IJUIL
	***	()	1. Decedent's Name (First, Middle, Las	st)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		SHIRLEY			REZ	ZNICK	May	10	2006	16 20 M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, T	own, or Location of De		4c. Cou	nty of Death	
			Sinai Hospital	of Baltimon	_	B	laltimore	City		N/A	
*** E.	uneral		5. Social Security Number 6. S			If Under 1		s. 8. Date of Bi	rth	9. Birthr	place (State or Foreign
100	rector		119-18-3232	□M 2QF 82	Yrs.	Months	Days Hours Mi	8. Date of Bi (Month, D. 12/14/	1923	Cou	N.Y.
100	A #	Ì	Usual Residence of Decedent	λ OL							
fand	Mo #	Ì	10a. State 10b. County	10c. Cit	y, Town or L	ocation	· · · · · · · · · · · · · · · · · · ·			1	10d. Inside City Limits
Man	9 3	ō	MD	N/A BAL	TIMORE	-					1√ Yes 2 No
the state of	28a	ec.	10e. Street and Number	N/A DAL	TIMORE	10f. Zip 0	Code		10g. Citizen	of What Cou	ntn/?
with	0 4	₫	7218 PARK HEIGHT	C AVENUE			1215 2120 8			U.S.	*
heeth	8 23	Funeral Director		12. Was Decedent Ever in U.	S 12				0 14 5	Race - Americ	
e d	item	'n	11. Marital Status	Armed Forces?	.3.	If Yes, specif	ent of Hispanic Origin? fy Cuban, Mexican, Pu	erto Rican, etc.)	U. 14. F	Black, White,	
36 s aft	o'	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give		1 ☐ Yes 2	No Specify:		Spe	city:	WHITE
21215-0036 of within 72 hours aft giene.	E G			Year or Dates:					1		
72	u, iii	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	edent's Usual	occupation done during most of w eretired)	vorking	160. Kind of	f Business/in	austry
d digit	han a	E D	Elementary/Secondary (0-12)	College (1-4or 5+)			3 (80)		OH	N HOME	-
ygie	H H			4	HOUSE	TMILE	10.14.1	/F:			-
ind be fi	to b	Be	17. Father's Name (First, Middle, Last,	,	Г	-10		ame (First, Middle		,	CTEIN
Value Men	aric mric	ဥ	MOSHE			ELD	TZIVI	LA E	STHER	ПАКІ	TSTEIN
Maryland 21215-0036 at 2 should be filed with 172 hours after deeth with the Maryland the and Mental Hyglene.	item 27 is marked other than "natural", or items 23s or 28s-f shov other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address ((Street and Number or	Rural Route Numb	er, City or To	wn, State, Zip	code)
and and	er tr		HARRIET REZNICK	/ DAUGHTER	305	WEST I	END AVENUE	#1018 -	NEW YO	RK, N.	Y. 10023
Saltimore, Permit. Pages 1 a	important: If item 27 is any injury or other tra once.		20a. Method of Disposition	20b. P	lace of Disp	osition (Name	e of	Date		on - City or To	
MOF Pages nent of B	יי פין		1 N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State BE	TH TSR	AEL ory or oth	05	/12/2006	CHARL	ESTON	, S.C.
artm	infu		21. Signature of Funeral Service Lices		2	2. Name and	Address of Facility	SOL LEVIN	SON &	BROS	INC.
Balti permit. Departr	any ir		by Alland	7 \			EISTERSTOWN				
			23a. Parti. Enter the disease, or/com	plications that caused the deat						1225	Approximate
-			shocks or heart failure. List offy			itei ille illoge	or dying, such as card	ac or respiratory i	111051,		Interval Between Onset and Death
16	sician		Immediate Cause (Final disease or condition	Metas	tatic	Po	ancreatic	Cancel			
	edical		resulting in death)	Due to (or as a conseq	uence of):						
⊏Xa	miner		Sequentially list conditions	b							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uerice of).						
K 68760, ertificate be executed	ansi	Examiner	Cause (Disease or injury that initiated events	c							
exe	ial-ti	EX	resulting in death) Last	Due to (or as a conseq	uence of);						
92	sicie bui	a		d							
68760,	s the	Medical									
Certi	attending physicien and for use as the burial-transit		IF FEMALE:	23c. If yes, outcome of pregna	incy				234	Date of deliv	/en/
BO.	for t	iar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	□Ectopic pre □ Other (spe				Month	Day Year
o §	the hed	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	5 4111 51	Cities (spe	cny)				
I Records, P.O. Boy The law requires that the death o	been signed by the attend should be detached for us		Part II. Other significant conditions of	contributing to death but not res	ulting in the	underlying car	use gwen in Part I	23e Did	tohacco use c	ontribute to t	the cause of death?
S S	be o	b	Tarris Strong Signatura Conditions	continuum g to doubt but not res	aiting in the t	underlying ca	uso given in Faith.				bably 4 Dunknown
orc equi	ould sen	ted		· · · · · · · · · · · · · · · · · · ·				- 4	Yes 2 No	- 3 [] FIO	bably 4 DOTKHOWN
Vital Records,	2 5	Completed						24a. Wa	s an 24	b. Were auto	opsy findings available ompletion of cause of
E SE	age age	шо						peri 1 ☐ Yes	ormed?	death? 1 ☐ Yes	
	tifica tor, p	0	25. Was case referred to medical				26 Place of D	eath (Check only			y at no
	s cer	To B	examiner? 1 ☐ Yes 2 % No	Hospital: Inpatient 2	ER/Outpatie	ent 3 DOA	Other	Home 5□ Res		Othor (Soon	(6.1)
Phy.	r thi	T :	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				how injury oc		197
ding ding	Afte	tior	1 Natural 5 ☐ Pending 2 Accident investigatio		Injury	м	3c. Injury at Work? 1 ☐ Yes 2 ☐ No				
Vision Attending	ctor. y the	lica	3 Suicide 6 Could not b	00 - 01 11-i 11-i	ome farm of			28f Location	(Street and Ni	imber or Rive	al Route Number.
Division i or Attending efter death.	Dire in b	Certification:	4 Homicide determined	building, etc. (Specif	y)	set, ractory,	500		wn, State)		
pitai	eral		20a Cartifice 45A a. etc.	- I							
Div the Hospital or hin 24 hours efte	the Funeral Direction place in by	Ca	(Check only 2 Medical Exam	nysicien: To the best of my knominer: On the basis of examina	wiedge, dea tion and/or i	itn occurred a nvestigation,	it the time, date and pla in my opinion, death oc	ice, and due to the curred at the time	e cause(s) and , date and plac	manner as s ce, and due t	stated. to the cause(s)
o the	i the Funeral Director: After this certificate ha mpletely filled in by the funeral director, page	Medicai	Une)	and manner stated.							
0 ≅	0 5	-	29b. Signature and title of certifier	and the second s		29C.	License number		29d. Date sig	arreu (MONTA),	, way, 1821/

State Registrar

29b. Signature and title of certifier

PRANITHA

31. Date filed (Month, Day, Year)

MAY 1 2 2006

NAINI, MD, SINAI HOSPITAL . Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RESIDENT

15794

BALTIMORE

		State of Maryland / Departme		•	e _{o o o}	1 = 0 1 1
		. FOR	te of Death	Reg. N	ZUUb	15011
	<u>1</u> 16-	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	ay Year	3. Time of Death
Physic /Medi		Edward Shegogue		MAY 4	2006	1828PM
Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City	y, Town, or Location of Death		c. County of Death	
	4 4	Doctors Community Hospital Lan 5, Social Security Number 6, Sex 7, Age (In yrs. last birthday) If Und	or 1 Year If Under 24 Hrs.	9 Date of Right	Prince Go	lace (State or Foreign
Funeral Director		577-18-5797 1⊠M 2□F 89 Yrs. Months	Days Hours Min.	Oct 23, 19	16 Mary	Iand
\$'		Usual Residence of Decedent				I.Od. Inside City Limits
arylar show	r.	10a. State 10b. County 10c. City, Town or Location				1 ☐ Yes 2 ☑ No
the M	ecto	MD Prince Georges New Carrollt 10e. Street and Number 10f. 2	ip Code	10g, C	itizen of What Cour	ntry?
With Sa or	Funeral Director		784	US	٨	
death ms 2:	nera		edent of Hispanic Origin? (Spe ecrly Cuban, Mexican, Puerto I		14. Race - Americ Bfack, White,	
after or its	/Full	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	2₺ No Specify:	110411, 010.7	Specify:	olo.
iled within 72 hours after death with the Maryland Hygiene. Hygiene. Inter than "natural", or items 23a or 28s-1 show only the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced 1178s, Give Year or Dates: 141-46 15, Decedent's Education 16a. Decedent's Us	ual Occupation	16h	whi Kind of Business/In	
in 72	olete	(Specify only highest grade completed) (Give kind of v	vork done during most of workii	ng TGD.	, card of oddinoddin	unk
d with giene.	Completed	Elementary/Secondary (0·12) College (1·4or 5+) 12 2 Busines	s			
be filed within 72 hours after death with the Marylan stal Hygiene. ad other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be notified at	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	n Sumame)	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, it a Mental	To	Walter Edward Shegogue		Rebecca He		- 0 - 4 - 1
Mand hand 7 is m			ss (Street and Number or Rura			
permit. Pages 1 and 2 should permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic and pages.		20a Method of Disposition 20b. Place of Disposition (N			Location - City or T	
Pages ent of t: Fi		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Other place)			
mit. F partm porter y inju		21. Signature Funeral Service Lynsee 22. Name	and Address of Facility	(55 tr D	1	
Depariment Department of the partment of the p			Anatomy Board more, MD 21201		itimore :	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.	ode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	death			
/Medical Examiner		Due to (or as a consequence of):	udial intert	tras		
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	rain infair	CNOW!		
ate be executed hysicien and he burial-transit	Examiner	that initiated events	in otesias			
e be executed sicien and burial-transit	Ex	resulting in death) Last Due to (or as a conset of celof):	J			
ate by ohysic the bu	dical	d				
Se as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	1000		23d. Date of deliv	erv
Death atten	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No			Month	Day Year
by the	hys	9 □ Unknown				
s tha gned	by P	Part If. Other significent conditions contributing to death but not resulting in the underlying	cause given in Part I.			the cause of death?
w requires t been signe should be				1 🗆 Yes	2MN0 3 Pro	bably 4 Unknown
e 2 sh	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available empletion of cause of
al n n: The ficate v r, pag		ediaco e de caración de caraci		1□ Yes 2☑1		2 No
Sician certif rector	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 ☑ Ft/Outpatient 3 □	Other	me 5 Residence	€ □Other (Spec	(he)
Phy er this	 	27. Manner of Death 28a. Date of fnjury 28b. Time of		28d. Describe how in		(4)
r Attending or death.	atlo	2 Accident investigation	1 ☐ Yes 2 ☐ No			
r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farm, street, fact building, etc. (Specify)	ory, office	28f. Location (Street City or Town, Sta		ral Route Number,
urs af			d with the same data and along	and due to the serves	(a) and manner no	stated
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 4 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
Fo the Within Fo the	Me	29b. Signature and title of certific	29c. License number	29d. [Date signed (Month	, Day, Year)
, ,, ,		+ this k Hohay	00060339		0> 104 3	2006
		30. Name and address of person who completed cause of death (frem 23a) (Type, Print)		1 1.	Malan	Osal-
July Company		Khalid Ashai 8100 Good Luck Kond 31. Date filed (Month, Day, Year) 32 Registrar's Signature	1 Sinte 302	Lannam	11400	106
S Regis	tate trar	31. Date filed (Month, Day, Year) 32 Registrar's Signature	on, in my opinion, death occurry 29c. License number 90060339 d Shite 302			

Shegogne,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year SKELTON 8:59 10 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) ARBOR ENTER BAI TIMORE HOSP N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 🖾 F 214-20-1545 Usual Residence of Decedent July 14,1915 Virginia 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🗷 No Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7885 Gordon Court number 572 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 N/AHomemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Brooke Joseph Carter Betty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Calvert (Daughter) 6314 S. Orchard Road Linthicum Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 5/13/06 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. allins 3204 Mountain Road Pasadena, Maryland 21122 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATOR Three Days Due to (or as a consequence of) END STAGE LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ENC ANOXIC that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. 1 Records, Division of Vital in Nows after death.
In 24 hours after death.
The Funerel Director: After the funerel of the fun To the within 2.

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

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Examiner

Be Completed by Physician/Medical

Medical Certification: To

(Check only one)

29b. Signature and title of certifier

Funeral

Director

al Hygiene.
I Hygiene.
I other then "nature!", or Items 23s or 28s-f show

permit. Pages 1 end 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a eny injury or other treumatic event, the Medical Examiner mutal page.

Physician

physicien and the burial-transit

Baltimore, Maryland 21215-0036

Registrar

MD

29c. License number RES 000

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANOVER STREET, BALTIMORE, MARYLAND XIAOGUANG SUN 3001 5 31. Date filed (Month, Day, Year)



Luc

Please Type or Print in Black Indelible Ink

cy W	/ing-Yee s		m State of Maryland / Department - For State Registrar Certificate			and	Menta	ΙНу		g. No	200	16 1501
	Physicia	an/	Decedent's Name (First, Middle,Last)					2	Date of Deat		Year	3 Time of Death
edica	al Exami	ner	LUCY WING-YEE SHUM						May 10, 20	006		2122 hrs
			 Facility Name (if not institution, give street and number) W. Madison Street, Apartment 6 	4	b. City, Tov Baltimo		cation of L	Death		40	. County of Dea	ıth
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda	av)	If Under		If Under 2	24Hrs.	8. Date of Birt	h (MM/		irthplace (State or
	Director		439-17-6593 1 M 2 X F 33	Yrs.	Months	Days	Hours	Min.	August		Fore	
		1	Usual Residence of Decedent	115.					August	JI,	17/2	Thorig Rong
	any	ı	10a. State 10b. County 10c. City, Town or	Locatio	on							10d. Inside City Limits
	snd show	ᅵ	Maryland n/a Baltimo	re								1 X Yes 2 No
	Maryli 28a-f d at o	Director	10e. Street and Number		10f. Zip Co				10	-	zen of What Co	untry?
	ith the Maryland 23a or 28a-f show any notified at once.		20 W. Madison Street Apt. 6		212	201				U	.S.A.	
	ems 2	Funeral	11. Marital Status 1 X Never Married 2 Married 2 Armed Forces?		Decedent es, specify (cify Yes or No- ican, etc.)		14. Race - Ame White, etc.	erican Indian, Black,
	or it	쾹	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	4 FT	Yes 2 5	ł No.	ananih.				Canait Ol-	•
	urs aft	₫	or Dates:		's Usual Oc	•		d of wo	rk done		Specify: Ch	inese
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036	ithin ine. r thai	Completed	5+	La	awyer						Group	
5-0	iled w Hygie I othe the N		17. Father's Name (First, Middle, Last)					,	irst, Middle, N	laiden		
21215-0036	d be f fental narke event,	o Be	Shu Shum 19a Informant's Name/Relationship (Type, Print) 19b. N	Anilina	Addross	Ctroot 5	Serey	7 D	and Dougla Niver	h 0	Yeun	g
MD 2	shou and A 7 is n	۲									as 7910	· · · · · · · · · · · · · · · · · · ·
<u>ک</u>	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	20a. Method of Disposition 20b. Place of D	isposi	tion (Name				Date		Location - City	
Baltimore,	ages latt of l		1 X Burial 2 Cremation 3 Removal from State crematory 4 Donation 5 Other Specify.			n Co	mt	5-1	5-06	Ta	coma Wa	shington
ıltin	nit. P artme oortan iry or		4 Donation 5 Other Specify: ITINITY 21. Signature of Funeral Service Licentee	22. N	ame and Ad	dress of	f Facility	Mit	chell-	Wie	lefeld	F.H. Inc.
ä	Dep Imi		(Colert Brats)			65	00 Yo	ork	Road B	alt:	imore.M	d. 21212
	nysician		23a. Part I. Enter the disease, or complicated that caused the death. Do not e failure. List only one cause on each line.	nter th	e mode of o	lying, su	ich as card	diac or r	espiratory arre	est, sho	ock, or heart	Approximate Interval Between Onset and
	Medical xaminer		Immediate Cause (Final disease a. Hanging									Death
1			or condition resulting in death) Due to (or as a consequence of):									
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
	nted d ansit	Ä	events resulting in death) Last Due to (or as a consequence of):									
	execuian an	edical	UNPENDED AMENDED						-			
,09	ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and functral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy			-				23	d. Date of delive	ery
687	ding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Live birth 4 Pregnant at time of death		al death		Ectopic p	regnan	су		Month	Day Year
Box 6876	leath c e atter for us	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown	Oth	ner (Specif))						
	t the c		Part II. Other significant conditions contributing to death but not resulting in	n the u	nderlying ca	ause give	en in Part	I.	23e. Did to	bacco	use contribute	to the cause of death?
P.O	res tha signed be de	d by							1 Yes	2 🗸	No 3 Pr	obably 4 Unknown
rds	been been	Completed							24a Was autop			autopsy findings available ocompletion of cause of
ဝ၁	he law ate has age 2 s	E E						_	perfo	rmed? 2 ✔ N	death?	
띪	an: T ertifica stor, pa	Be	25. Was case referred to medical		26	Place of	f Death (C	heck or				
Vit	hysici this c	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	atient	3 DO/	A 01	ther ₄ h	Nursing	Home 5	Reside	ence 6 🗸 Oth	ner: Scene
Division of Vital Records,	Jing Ph After t funeral	<u>∺</u>	27. Manner of Death 28a. Date of Injury 28b. Tin 1 Natural 5 Pooding May 10, 2006 0000 h				at Work?	IS	8d. Describe I ubject han			
iòr	death ctor: y the	atic	2 Accident Investigation				s 2 🗸 N	Ю				
į. į	of or A	Certification:	3 Suicide 6 Could not be determined (Specify) Multi Family Apt	n, stree	et, factory, o	ffice buil	lding, etc.		or Town, S	tate)		Rural Route Number, City
	ospits hours unera ty fille		4 Homicide									ment 6, Baltimore,
	To the Hospital or Attendir within 24 hours after death To the Funeral Director: A completely filled in by the fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or inve									
_	To wit Con	Mec	and manner stated. 29b Signature and title of certifier		29c. l	icense i	number			29d.	Date signed (A	fonth, Day, Year)
			() a lologgan		(D.C.M	.E.			May	y 11, 2006	
	,/		30. Name and address of person who completed cause of death (Item 23a)									
	19			⊃enn	Street, E	Baltimo	ore, MD	2120	1			
	S	tate	31. Date filed (Month, Day, Year) 32. Refistrar's Signature	1	ack s							

			For State Registrar	State of Ma	•	partment of F ertificate of			giene Reg. No. 0 0 (15014
	Physicia /Medic	an	1. Decedent's Name (First, Middle,	EUGENIA K	ITCHEN SE	EITZ		2. Date of De Month May	Day Ye 9, 2006	3. Time of Death 10:40 p M
	Examin	er	4a. Fecility Name (If not institution, Edenwald 5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthd	To	or Location of Death OWSON If Under 24 Hrs.	8. Date of Bin		more County Birthplace (State or Foreign Country)
L	Director		216-46-7597 Usual Residence of Decedent	1□M 2 X F	94 Yrs	Months Days	Hours Min.			ustria-Hungar
	Maryland -f show	tor	10a. State 10b. County	imore	10c. City, Town o	Location				10d. Inside City Limits 1 ☐ Yes 2X No
	or 28e	Director	10e. Street and Number			10f. Zip Code	***		10g. Citizen of Wha	Country?
	sath w		800 Souther	12. Was Decedent I	Ever in U.S.		286	acify Ves or No	USA	American Indian,
36	72 hours after death with the Maryland naturel; or items 23s or 28e-f show Jical Examinat the notified al	by Funeral	11. Marital Status 1 Never Married 2 Marrie **Widowed 4 Divorced	Armed Forces?	No	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes ②○XNo		Rican, etc.)	Black, V	white
21215-003		Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		(G	ecedent's Usual Occu tive kind of work done e. DO NOT use retire	during most of won	king	16b. Kind of Busin	ess/Industry
	e filed within Il Hygiene. other than "	Con	47 Fabrica Name (Fine Middle)	3		Funeral D		- (First Middle	Funeral	Service
Maryland	ed its b	To Be	17. Father's Name (First, Middle, L		Scibajlo		18. Mother's Nan	Maria		
ary	0 4 2 9		19a. Informant's Name/Relationsh	, ,		ailing Address (Street	t and Number or Ru	rai Route Numb	er, City or Town, Sta	te, Zip Code)
	ts 1 and of Health item 27 other tr		John O. Mitchel 20a. Method of Disposition	ll III-Execu		york Road	d, Baltim	ore, MD	21212 20c. Location - City	or Town. State
altimore,	Pages nent of int: If its iry or o		XX Burial 2 Cremation '4 Donation 5 Other (Sp		cemetery.	crematory or other pla		5/06	Baltimore	
Balti	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service L	icensee III		22, Name and Addr. Mitchell-1 6500 York	ess of Facility Wiedefeld	Funera	1 Home, Ir	nc.
	Physician /Medical Examiner	iner	23a. P. 1. Enter the disease, or Shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	aa	a consequence of)	Looke	yo tic			Approximate Interval Between Onset and Death
. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	ey		23d. Date o Month	delivery Day Year
, P.O	res that the de signed by the a be detached	by Phys	9 Unknow	9□ Unknown ns contributing to death b	ut not resulting in th	ne underlying cause gi	ven in Part I.	23e. Did t	tobacco use contribu	te to the cause of death?
ord	w require been sig should b				· · · · · · · · · · · · · · · · · · ·			10	Yes 2 10 3	Probably 4 Unknown
I Records,		Completed						24a. Was auto perfo 1 \(\text{Yes}	psy prio dea	e autopsy findings available to completion of cause of h? Yes 2 \(\subseteq \text{No} \)
Vital	yeician: The is certificate his director, page	Be	25. Was case referred to medical examiner?	Hospital:		0:	26. Place of Dea			
Division of	ding Ph h. After th funeral	tion: To	1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Inju (Month, Da	ent 2 ER/Outpo iry 28b. Tirr y Year) Inju	ne of 28c. Injury	4 Nursing H		idence 6 Other (Specify)
Divis	in Dir	Certification:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of Inj	ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (City or To	(Street and Number own, State)	or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C		g Physicien: To the best Examiner: On the basis o and manner st	f examination and/					
,	To the To the comp	Me	29b. Signature and title of certifier	//	1		ise number		29d. Date signed (A	
Ī	,		30. Name and address of person	who completed cause of o	h h 1 L	rean)	247	64	5/1	0/06
	6	1	Marue (wo 31. Date filed (Month, Day, Year)	D. Albrer 32. Registr	wo Wy	5/6N.	Kolling	Pd 1	Bn Ho h	2/228
*	Sta Regist		MAY 1	2 2006	. 4	A	•			

			1 - State Registrar	State of M	larylan				ealth a Death	ind Me		iene _{eg. No.} 20	06	15	015
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Anna Stroumbi	s							2. Date of Deal Month May	h Day	Year 2006	3. Time o 2:15	
	Examin		4a. Facility Name (If not institution, give st Stella Maris				Timo	nium					ltimo	re	
	Funeral Director		5. Social Security Number 217-24-2118 Usual Residence of Decedent	7. A	ge (In yrs.	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, June 18	, 1928	9. Birth Cou Mart	place (State intry) Lyland	or Foreign
	th the Maryland or 28a-f show	Director	10a. State 10b. County Maryland Baltimore 10e. Street and Number		10c. Cit	y, Town or Lo		timor Code			1	0g. Citizen of	What Cou	intry?	City Limits
036	within 72 hours aftar death with the Maryland ene. then "natural", or items 23a or 28a-f show the Mudical Exeminer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	? No		Was Dece f Yes, spe 1 🗆 Yes			236 gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		ck, White	ican Indian,	
Maryland 21215-0036	filad within 72 ho Hygiene. other then "naturent, the Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12		5+)	16a. Deced (Give life. I	kind of wo	ork done d se retired	ouring most ent			16b. Kind of E	Estat	•	
yland	o a in o ≥	To Be	17. Father's Name (First, Middle, Last) Louis Mavrides					10	Zoe	. Р	(First, Middle, I	es			
	1 and 2 s Health ar em 27 ie ther trau		19a. Informant's Name/Relationship (Typ Mr. James Stroumbia 20a. Method of Disposition				7 Wes	stmea		ad,	Route Number Baltimo		2123	36	
Baltimore,	Page nent c ant: if ary or		1 A Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		. 0	emetery, crer Demet	natory or NOS	Ch.	Cem.	5/13	/2006	Baltim	ore,	Marylo	and
Ba	permit. Depertrimporta		23a. Part1. Enter the disease, or complic		ed the deat	9	705 E	Belai	r Rd.	, Ва	imunek ltimore	, MD 2		Approxima	ite
8760,	Physician /Medical Examiner the purial-transit in punial-transit	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyking Cause (Disease or injury that intilated events resulting in death) Last	LUNG (Due to (or a Due to (or a	S a consequence s a consequence s	uence of):								Interval Be Onset and	Death
O. Box 6	The law requires thet the deeth certificat ite hes been signad by the ettending phy tage 2 should ba deleched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	Ectopic p Other (s						ate of delin	very Day	Year
rds, P.	quires thet an signad b uld ba det	by	Part II, Other significant conditions conf	ributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I.		i	bacco use con es 2 □ No			
of Vital Records,		Completed									24a. Was a autops perfor 1 Yes	SV	Were aut prior to c death? 1 \(\text{Yes}	opsy findings ompletion of 2 No	available cause of
Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 🏋 No	ospital: 1 ⊡ Inpai	ient 2 🗆	ER/Outpatier	nt 3□ D	OA Othe			Check only or		her (Spec	(v) HOSI	PTCE
	ing Viter une	ation; T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		28c. Injun Work		2	8d. Describe h				702
Division	in the se	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury · At h etc. <i>(Specil</i>	ome, farm, str (y)	eet, factor	y, office		2	8f. Location (S City or Tow		ber or Ru	ral Route Nur	mber,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examin		of examina										(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier				29	D4	372	5	2	9d. Date sign	ed (Month	,	
	6		30. Name and address of person who compared to the second			n 23a) (Туре, VEY VAI					MD 210)93			
	Sta Regist		31. Date filed (Morth, Day, Year) MAY 1 2 200	39 Regis	trar's Signa										

MAY 11, 2006 2:15 a.m.

ANNA STROUMBIS

		•	For State Registrar	State of Ma	aryland /		rtment of F tificate of			•	giene Reg. No	2000	And the second s	5016
体			Decedent's Name (First, Middle,						2	. Date of De Month	ath Da	ay Year	3. Tin	ne of Death
	Physici /Medio		Ladislav S	oucek						ME	Y E	3, 2006	9:4	P M
>	Examin	er	4a. Facility Name (If not institution, Saint Joseph		Center		4b. City, Town, o		of Death		40	c. County of Dea	th cimor	- D
	<u> </u>				e (In yrs. last t		If Under 1 Year	If Under		. Date of Bir	th	9. Bir	tholace (St	ate or Foreign
	Funeral Director		124-46-1413	1 M 2□ F	80	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year	925 Czec	chose	vakia
	p		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	was or Lo	nation						10d Insid	de City Limits
	ehov	ö	Maryland Balti	M 0 H 0	Toc. Oily, To	ANTI OF LO	Perry H	089						Yes 2 No
	28a-1	Director	10e. Street and Number	aurce			10f. Zip Code	ui.			10g. Ci	itizen of What C	ountry?	
	3a or		4425 Forge Ro	ad				21128				U.S.A.		
	deeti	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H	lispanic Or	rigin? (Specif	fy Yes or No)-	14. Race - Am Black, Whi		ın,
336	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Expluiter mast be notified at ance.	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	No		☐ Yes 2X No	Specify		· · · · · · · · · · · · · · · · · ·		Specify: W		
Maryland 21215-0036	72 hoi	Completed	15. Decedent's (Specify only highest	Education grade completed)	16	(Give	ent's Usual Occup	during mos	st of working		16b. l	Kind of Business	/Industry	
7	Aithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	00 NOT use retired Pattern	d)			Aus	to Manu{	Cotus	10 h
2	Hygier ther th	Ö	17. Father's Name (First, Middle, L.	ast)	Įγ	ieru	racein			First. Middle	<u> </u>	n Sumame)	juciu	
and	d be f ental h ked of	To Be	Josef Souc									manova		
ary	shoul ind Ma mari	F	19a. Informant's Name/Relationshi			9b. Mailin	g Address (Street	and Numb	er or Rural F	Route Numb	er, City	or Town, State,	Zip Code)	
Ž	and 2 palth a n 27 le		Mrs. Alena Gard	os (daught	_		Flowerin	g Che						
altimore,	of He of He of Item or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	B □Removal from State	ceme	tery, cren	sition (Name of natory or other place		Dat			Location - City o		
Ē	t. Pag timent rtant:	١.,	4 □ Donation 5 □ Other (Spe	ecify)	Bayux		rematory . Name and Addre					timore,		Kand
Ba	Depar Impo		21. Signature of Funeral Service Li	3° 5 (705 Bela							
			23a. Part1. Enter the disease, or of shook, or heart failure. List of	omplications that cause nly one cause on each I	d the death. D	o not ent	er the mode of dying	ng, such as	s cardiac or r	espiratory a	rrest,			l Between
	Physician		Immediate Cause (Final disease or condition	_a_PULMON	IARY E	IBRO	SIS						Onset	and Death
	/Medical Examiner		resulting in death)		a consequenc	ce of):								
		-e	Sequentially list conditions,	b. ACIDOS	i L to a eunsaquene	oe of):								
1	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
v O	e exectan an an urial-tr	Exa	resulting in death) Last		a consequenc	ce of):								
8760,	icate be executed physician and s the burial-transit	dlcal		d										
9	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							23d. Date of de	alivery	
Вох	es that the death certifi igned by the attending I be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea	ath 3⊑	Ectopic pregnancy Other <i>(specify)</i>	у				Month	Day	Year
0	t the c by the achec	hysl	9 Unknown	9□ Unknown		-								70/22
o,	ss tha gned I	by P	Part II. Other significant condition	s contributing to death I	out not resulting	g in the u	nderlying cause giv	en in Part	l.			use contribute		
ord	wrequire been si should l	ted								10	Yes 2	2 □ No 3 □ F —	robably	4 Unknown
Records,	B 8 C	Completed								24a. Was	an psy ormed?	24b. Were a prior to death?	completion	lings available n of cause of
alF									- 7.2	1 ☐ Yes	2 X N			
Vital	Phyaician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2∏ FR/	'Outpatien	t 3 DOA Ott	or:	e of Death			6 ☐Other (Sp	ecify)	
0	g Phy er this ieral c	11	27. Manner of Death	28a. Date of Inj.	ury 28b	b. Time of		ry at				ury occurred		
joi	Attending or death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident Investig	ition	2) 702.7	IIII		Yes 2]No					
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zoe. Place of it	jury - At home, tc. <i>(Specify)</i>	, farm, str	eet, factory, office		28	If. Location (City or To		and Number or F ite)	Rural Route	Number,
_	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in		29a. Certifier Certifying	Physician: To the best	of my knowled	dge, deatl	n occurred at the ti	me, date a	nd place, an	d due to the	cause((s) and manner a	as stated.	
	the Ho in 24 the Fu	Medical	one)	xaminer: On the basis of and manner s		and/or in			ath occurred	at the time,				
	To T To I	Σ	29b. Signature and title of certifier	111		1	29c. Licens	se number			29d. D	Date signed (Mor	nth, Day, Ye	ear)
,			F.Wh	Khosron	(1d	bar	D46:	356			Ma	18,2	006	
	12		30. Name and address of person v					, p grava :-	ngan pang s s oom com		/		m, g .m., .m.	
1	Str	ate	31. Date filed (Month, Day, Year)	2. Regist	7601 rar's Signature	USL	ER DRI	V lim y	TOWSO	и, П	4K.X1	LAND :	= 1 = 1/1/	+
	Regist	rar	MAY 1 2 21	Chr.	, the	4000								

06-03103

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Barbara Santiago Certificate of Death 1- For State Reg No Registrar Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day 0436 hrs May 8, 2006 **Medical Examiner** Barbara Cecelia Santiago 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore City** N/A University Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number Age (In yrs. last birthday) 6. Sex 'Funeral Foreign Country) N.Y. Days Hours 9, 1939 Oct. Director 66 056-30-2234 2 X F Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State any 1 Yes 2 X No Churchville Harford 28a-f shov or items 23a or 28a-f show must be notified at once. Md. Director log Citizen of What Country? 10f. Zip Code 10e. Street and Number 21028 U.S.A. 306 Middleton Court 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes white Specify: 1 Yes 2X No specify: If Yes, Give Year hours after Widowed 4 Divorced Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene and if Health and Mental Hygiene and if Health and Ti is marked other than "natural", rother traumatic event, the Medical Examiner. ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Harford County College (1-4 or 5+ Elementary/Secondary (0-12) 21215-0036 government office manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Conolly Michael DePalma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 306 Middleton Court, Churchville, Md. 21028 N N Paul John Santiago, Sr./husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 ACremation 3 Removal from State Department of Important: I Bayview Crematory 5/10/2006 Baltimore, Md. Donation 5 Other Specify 22 Name and Address of Facility
Schimunek Funeral Home of Bel Air, 21. Signature of Funeral Service Licensee un le We 21014 610 W. MacPhail Road, Bel Air, Md Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Death /Medical a. Hypertensive left basal ganglia hemorrhage Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last executed and Physician/Medical UNPENDED AMENDED vsician Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c If yes, outcome of pregnancy e attending physics for use as the b Day 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown ş σ. Division of Vital Records, pleted s been s 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? After this certificate has Com 2 No ✓ Yes 2 1 🗸 Yes page 26 Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other Hospital: 1 / Inpatient examiner? ER/Outpatient 3 DOA 1 🗸 Yes 2 No 2 28d. Describe how injury accurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No 5 Pending 24 hours after death. Funeral Director: the Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 3 Suicide 6 Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 8, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner harles re ial Security Number 6. Sex Year 9. Birthplace (State or Foreign **Funeral** Months Days Min. 217-84-716. Usual Residence of Decedent Hours 1 M 2 □ F Yrs. Director 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or Itema 23a or 28a-1 ehow ury or other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Maryland

10e. Street and Number 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status - American Indian Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) /Secondary (0-12) College (1-4or 5+) bore 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ၉ 19a. Informant's Naple/Relationship (Type, Print) 19b. Mailing Address (Street and Number 904 E, E Place of Disposition (Name of 20b 20a. Method of Disposition 20c. Location -City or Town, State permit. Pages Department of I Important: If It any Injury or o cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility JOSEPH L. Ru ZZZZ W. North 21. Signature of Funeral Service Licensee h L Ry W. North Home Funeral 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** Advance disease or condition resulting in death) Stage Kan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the daath certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 √ 0 24a. Was an this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 0 Medical Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 Danatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of centries 29d. Date signed (Month, Day, Year) Than Room, M), COUD, FAEP D 57088 May 10, 2006

State Registrar

DHMH 17 Rev 1/2001

Birtimon, m)

Paul Place, # 701,

person who completed cause of death (Item 23a) (Type, Print)

38. Registrar's Signature

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MAY 1

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31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylar		nt of Health and ate of Death		4000	15019
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•	Examin	ier	CONCENTRATION OF SE	2-00	40.01	A = A = A = A	-	L COUNTY OF DEATH	
			5. Social Security Number 6. Sex	7. Age (In yrs.	Jast highday) If Lind	er 1 Year If Under 24 Hr	s. 8. Date of Birth	F44(5)	pplace (State or Foreign
	Funeral Director			M 250F 86	Yrs. Month			Year) Coi	untry)
			Usual Residence of Decedent	90			10/21 4 1	111	16:111FC
	ylend * •		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
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٥	or Its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		ecify Cuban, Mexican, Puè	rto Hican, etc.)	Black, White	etc.
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Mar	and and ie mu		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Addre	ss (Street and Number or F	lural Route Number,	City or Town, State, Z	ip Code) 31784
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			31. Date filed (Month, Day, Year)	Pagistrar's Sings	es's way	Stick Ec	D6-2200d	MID DUE	34
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Please Type or Print in Black Indelible Ink Richard Michael Stewart State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day 8, 2006 **Medical Examiner** 1207 hrs Richard M. Stewart 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bedtime Inn. Room 105 Ocean City Worcester 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) Foreign Months Days Hours Director 1949 Country) MI 373-48-6664 1 X M 2 F 56 8 Jul. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 Yes 2 XNo MI Grand Traverse Traverse City Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 2578 Devil's Dive Road 49686 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be Armed Forces? White, etc. 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year 3 Widowed 4 Divorced Yes 2 x No specify: white Specify. white à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene Important: If item 27 is marked other than "I injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 5+ Attorney Allied Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Albert Stewart Delores Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2578 Devil's Dive Road Traverse City, MI 49686 Debra Kay Stewart - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation crematory or other place) Removal from State Metro Crematory May 11, 06 Baltimore, Maryland Donation 5 Other Spe Surpature of Funeral Service 22. Name and Address of Facility Cremation Society 299 Frederick Rd. a 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death atherosclerotic cardiovascular disease Hypertensive heart disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical item#23a,27,perME,g856,6/8/06 T T// item#23a,perME,g857,7/15/06 TT X UNPENDED the attending physician ed for use as the burial -X AMENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate h ✓ Yes 2 No 1 🗸 Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other₄ DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 this 1 V Yes 2 No After th 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural death 5 Pending 1 Yes 2 No Funeral Director; stely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and t 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. May 9, 2006 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Registrar's Signature

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		-	Decedent's Name (First, Middle, La.	st)						2. Date of Deat Month	h Day	Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, giv Harford Memoria				4b. City, Town, or Havre d					inty of Death ${f rford}$	
-	Funeral		5. Social Security Number 6. S		ge (In yrs. last b	irthday)	If Under 1 Year	If Under 2		B. Date of Birth (Month, Day,			place (State or Foreign
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and	S E D	To Be	William L. Matthe					Gert	rude	(Blose	e) Ma	tthews	
ary	# PE		19a. Informant's Name/Relationship (Туре, Print)			ng Address (Street						Code)
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O. Box	The law requires that the death certificate be executed as has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal dea at time of death		□Ectopic pregnancy □ Other (specify)				23d	l. Date of deliv Month	rery Day Year
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rds	w require been sig should b	ed b								1 🗆 Y	es 2 21	√o 3 □ Pro	bably 4 Unknown
of Vital Records,	sician: The law rus certificete has be lirector, page 2 sh	Completed					<u> </u>			24a. Was a autop: perfor 1 Yes	sy ,	24b. Were aut prior to o death?	opsy lindings available ompletion of cause of 2 No
Vita	Physician: r this certifice ral director, I	Be	25. Was case referred to medical examiner?	Hospital:	,		ot 3 DOA Oth	05		(Check only or			
of	Phys r this ral dir	.: To	1 Tes 2 No	28a. Date of Ir	njury 28t	o. Time o	III 30 DOA	4 🗆 140		ne 5 Resid 18d. Describe h			ity)
ion	Attending Port death.	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury		k? Yes 2 □!	No				
Division	el or Atts s after dei il Directo id in by th	Certification;	3 Suicide 6 Could not determined	286. Place of	Injury - At home, etc. (Specify)	larm, si	reet, lactory, office		2	28f. Location (S City or Tow		lumber or Ru	ral Route Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	thysicien: To the beaminer: On the basis and manner	of examination	ige, dea and/or i	th occurred at the time to the	me, date an ppinion, deat	d place, a th occurre	ed at the time, o	date and pl	ace, and due	to the cause(s)
	Withi To t	Σ	29b. Signature and title of certifier				29c. Licens	1104	124	1	MAY	igned (Month	-20n6
	12		30. Name and address of person who	10 190	8 140	r-fi	rd Rd.	Fal	130	n MI	21	047	,
	St Regist	ate rar	31. Date filed (Month, Day, Year)	S 2. Regi	strar's Signature	for	NE O						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item I per doc 8056 6-14-06 vt

State of Maryland / Department of Health and Mental Hygiene

				Glate of Ivia	aryland / i	Certificate				Reg. No. 0	16	15022
	B1 : :		1. Decedant's Nama (First, Middle	a, Last)					2. Data of Dea	ath Day	Yaar	3. Tima of Death
	Physicia /Medic		Tois Steiner	Lois Ste	iniger				February	13,2006		9:20 AM
	Examin	_	4a Facility Name (If not institution	n, giva street and number)				4b. City, Town, or L	ocation of Death			
			EAstpoint Nursing a	and Rehab. Cente	r		1	Dundalk		Baltim		
	Funeral Director		5. Social Sacurity Numbar unk	6. Sex 7. Aga 1 M 2 □XF 83	a (In yrs. last bi	Yrs. If Under Months	Days	If Undar 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 22,			laca (State or Foreign try) Ivania
	show	5	Usual Residance of Decedent 10a. Stata 10b. County			vn or Location					1	0d. Insida City Limits 1 □ Yas 2🛣 No
	the N	Director	Varyland Baltimor	<u>.e</u>	Dundal	10f. Zip	Code			10g. Citizen of \	What Coun	trv?
	with	늅		_								
	99th	era	1040 Old Northpoint	Pd 12. Was Decedant I	Evar in IIS	21224		lispanic Origin? (S		United St	ates e - Amaric	an Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperfurmant of Health and Mental Hygiene. Important: If them 27 is marked other than "hatural", or flems 23a or 28e-f show important: If them 27 is marked other than "hatural", or flems 22a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 □ Navar Marriad 2 □ Marr 3 ☑ Widowad 4 □ Divorced	Armad Forces? 1 ☐ Yas 2 ☒ N		If Yes, speci		dispanic Origin? (Stan, Maxican, Puerti Specify:	o Rican, atc.)		ck, White, V: White	
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<u></u>	lenta ked ked	ToB	unk	Starer				unk τ	nk.			
ary	2 should end Men e marke raumatic		19a. Informant's Name/Relations	ship (Type, Print)		b. Mailing Addrass						Coda)
Ž	end 2 salth e salth e r 27 ie		Harry Steninger, Sor	ı	13	21 Marsh Gr	ass	Court ,Jac	exanville,	Florida 3	32218	
Baltimore,	f Hei	-	20a. Method of Disposition		20b. Place o	of Disposition (Namery, crematory or of	ne of ther pla	ce)	Date	20c. Location -	City or To	wn, Stata
Ë	Pages nant of I ant: if ite		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (S						2/15/06	Timonium.	Maryla	nd
≣	orter	1	21. Signatura of Funeral Service		Luidiev							Pervices Of
ю́ —	Depentit. Depertrimporta		MSETU	1	M01113	Dulaney V	/alle	y,P.A. 200	Padonia F	d.,Timoni		21093
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	Examiner		disaasa or condition rasulting in death)	а		consequence of):	11	·			1	
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of Vital	ysici is ce dirac	10	examiner? 1 ☐ Yes 2√∑ No	Hospital: 1 ☐ Inpatie	ent 2 ER/O	outpatient 3 DO	A Oth	ner: Nursing H	loma 5□ Rasio	dance 6 □Oth	ner (Specif	y)
0 0	Attending Physician: or deeth. ector: After this certific by the funeral director.	stion:	27. Mannar of Death 1 Natural 2 Accidant 5 Pendir		ry y Yaar) 28b.	Time of 25 Injury M	8c. Injui Wo 1 □	ryat rk? Yes 2 □ No	28d. Describe	how injury occur	red	
_	7 # = c	Medical Certification:	3 Suicida 6 Could determ		ury - At home, f c. <i>(Spacify)</i>	farm, straat, factory	, office		28f. Location (: City or Tox		ber or Rure	I Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	dicai C	29a. Cartiller 1 Certifyin 2 Medical	ng Phyeician: To the bast of Examiner: On tha basis of and mannar sta	axamination a	e, death occurred a nd/or invastigation,	at the ti	me, data and place opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as s and due to	tated. o tha cause(s)
	ithin o the ompl	Me	29b. Signature and title of pertifie			29c	. Licens	se number		29d. Date signe	d (Month,	Day, Year)
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	29	- }	20 Name adada	1	noth (Itom 00=)		<u>.) () (</u>	06 0 56	<u></u>			
	V		30. Name and addrass of person Pankaj Khete				י אבע	North Drift Dri	ltimma M	21221		
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	Sta Registr		MAY 1 2		· A	Coules						

		ľ	1 - For State of Maryla		artment of H			ene g. No. 20	06 1502
			Decedent's Name (First, Middle, Last)				2. Date of Death)	3. Time of Death
	Physici		Carole Lynn Sloan				Month 9		76 16 50 M
)-	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of	f Death
			Peninsula Regional Medical C	enter	Salis			Wicon	mico
	Funeral		10M 25K	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 23	Year)	Birthplace (State or Foreign Country)
	Director		219-42-7435 62	Yrs.			June 23	, 1943 I	Maryland
	land			City, Town or L	ocation				10d. Inside City Limits
	Mary	į	Maryland Worcester	0ce	an Pines				1 ☐ Yes 2 🛣 No
	1 28a	rec	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	nat Country?
	h with	Funeral Director	7 Brookside Road		21811			United	States
	deat	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	lispanic Origin? (Specan, Mexican, Puerto F	city Yes or No-		- American Indian, , White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 ie marked other then "natural", or tems 23e or 28e-f ehow amy njury or other traumatic event, the Medical Examination intelliginal and once.	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2∏ No	Specify:			White
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give		during most of workin		16b. Kind of Busi	iness/Industry
2	Men.	mp	Elementary/Secondary (0-12) Cottege (1-4or 5+)		DO NOT use retired	d)		_ , ,	
7	fygier thert	ပိ	12 17. Father's Name (First, Middle, Last)	Su	<u>cervisor</u>	18. Mother's Name	(First Middle M		one Company
and	ntal h	Be	Earl Mowbray Baker			Audrey Ma			,
Maryland	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street	and Number or Rural			State, Zip Code)
<u>≅</u>	nd 2 s lith an 27 io 1 trau	İ	Richard B. Sloan, Sr. Husband			oad, Ocear			
ē,	thee the other		20a. Method of Disposition 20th	b. Place of Disp	osition (Name of matory or other place	Da			City or Town, State
Ë	Page ento nt: if ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Bernoval from State 4 ☐ Donation 5 ☐ Dther (Specify)	-	-	ons. May 13	. 2006 Ti	imenium. N	Marvlam
Baltimore,	mit. pertm pertm porta		21. Signature of Funeral Service Consee						eral Services of
Õ	88E 8 8		JUM 199 1 - 14.111	3 I	Julaney Vall	ley, P.A. 200) Padonia	Road, Tim	ronium, MD 21093
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not en	ter the mode of dyir	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. M(TRA)	IAWE (EPLACEUR	TU			1 DAY
ſ	/Medical Examiner								
Н	LAGITITIES		Sequentially list conditions, b. Due to (or as a conditions)		MSIFACE	wcy			(6)
	ted 1sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence or,					
	xecul and al-trar	Examiner	that initiated events c	sequence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the buriat-transit	lcal E	d						
9	tificat ig phy as the	ledi							
Box	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre 1 □ Live birth 2 □ F		□Ectopic pregnancy	y		23d. Date Mont	of delivery th Day Year
П	e dea the att	Physician/Med	in the past 12 months? 1 □ Yes 2 ⑤ No 9 □ Unknown 9 □ Unknown	of death 5	Other (specify)			Wickle	ar Bay Car
P.O.	ires that the de signed by the a f be detached f		Part II. Dther significant conditions contributing to death but not	resulting in the	inderlying cause giv	van in Part I.	23e. Did tob	acco use contril	bute to the cause of death?
ds,	signe d be (d by	CORONALY NOTERY DISPASE				1 ☐ Ye	s 2 No 3	3 ☐ Probably 4 ☐ Unknown
Records,	w require been sig	Completed					24a. Was ar	24b. W	/ere autoosy findings available
Re	The lav ate has page 2	dmo					autopsy	pr ned2 de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Vital	ician: Th certificate ector, pag	CO	25. Was case referred to medical			26. Place of Death			LI Yes ZUINO
<u> </u>	ysician: The is certificate hidirector, page	OB	examiner? 1 Yes 2 No Hospitat: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Ott	ner: 4 Nursing Hon			r (Specify)
n of	Attending Physician: r death. ector: After this certification in the funeral director.	n: T	27. Mann Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year	28b. Time tnjury	of 28c. Injui	ry at 2 rk?	28d. Describe ho	w injury occurre	od
Sio	eath. or: A the fu	catl	2 Accident investigation]Yes 2 □No			2 2
Division	or Att	Certification;	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp		treet, factory, office	2	City or Town		or or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Examiner: On the best of my	knowledge, dea	th occurred at the time	me, date and place, a	and due to the ca	tuse(s) and man	nner as stated.
	the H iin 24 the F iplete	ledical	one) and manner stated.						
	T N S O D	Σ	29b. Signature and title of cepitler		29c. Licens	3551		-	(Month, Day, Year)
	6		pow NU					101 ham	2606
1			30. Name and address of person who completed cause of death (James C. Todd, III, M.D. 201			, Suite 25	. Saliel	burv. M	21801
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's S		LALL NOUG	, Durce 25	Darra	JULY, PH	2 21001
142	Regist		MAY 1 2 2006	H	borle				
DH	IMH 17 Rev 1/2	2001							
				OHIC	SINAL				

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 George Michael 4, 9:50 A^{M} Shores May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1<u>M</u> M 2□ F 53 Yrs. 220-60-0592 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State other then "neturel", or items 23s or 28s-f show yent, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Rockville Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4701 Coachway Drive 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: unknown 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Express/ Elementary/Secondary (0-12) College (1-4or 5+) Kinkos Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin B. Shores Martha Kirchner 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st ment of Health and ent: If Item 27 is n ury or other traun Juliet Shores / Wife 4701 Coachway Drive, Rockville, Maryland 20852 20b. Place of Disposition (Name of commetery, crematory of other place of Pythias Cemetery May 13, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of importent: If eny injury or once. 2006 4 ☐ Donation 5 ☐ Other (Specify) Elizabeth, West Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Mydete Senso M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepatic

Due to (or as a consequence of): **Physician** tailure werk /Medical Examiner 1 hosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien and for use as the burial-transit Hershis highil Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred is or Attending Parties death.

Director: After to in by the funera Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 56652 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Conty- Drive, Rockwilly, MD Pottenan Matthew 31. Date filed (Month, Day, Year) 327 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 1 2 2006

		-	For State 1 - State Registrer	e of Maryland / Depa Cer	rtment of Health and I	Mental Hygien	ZUUO IJUZJ
	Physicia		Decedent's Name (First, Middle, Last)		0.55.7.11	2. Date of Death Month D	ay Year 3. Time of Death
	/Medic	al	ADA	-daymbar)	STEIN 4b. City, Town, or Location of Deatl	MAY 10	2006 4:00 A M
	Examin	eı	4a. Facility Name (If not institution, give street as LEVINDALE HEBREW HOME	ia number)	BALTIMORE		N/A
	Funeral Director		5. Social Security Number 6. Sex 1 M 25	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 8/12/192	9. Birthplace (State or Foreign Country) VA
	ס	l L	Usual Residence of Decedent	10c. City, Town or Loc	antion		10d. Inside City Limits
	Aarylar I show	ō	MD 10b. County N/A	BALTIMO			1/□Yes 2□No
	r 28a-	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	th with		2530 W. BELVEDERE AVEI		21215		U.S.A.
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other then "naturel; or Items 23a or 28a-f show other treumatic event, the Medical Examinating to maliked at	by Funeral	1 Never Married 2 Married 1 Hr	Voc 2 No	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
Maryland 21215-0036	vithin 72 hounder. hen "nature Neufort of the "nature of the "nature of the of	Completed		leted) (Give	lent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	Kind of Business/Industry
22	filed with Hygiene. Ithar ther		17. Father's Name (First, Middle, Last)	CLER		ne (First, Middle, Maide	
ılanı	ould be Mental arked o	To Be	SOLOMON	STEI			UNOBTAINABLE
	1 and 2 should i Health and Meni tem 27 le marker other treumatic		19a. Informant's Name/Relationship (Type, Prii ALAN CLAYMAN / FRIEND	1 FRA	g Address (Street and Number or Ri KLIN TOWN BLVD	- PHILADELP	(or Town, State, Zip Code) HIA, PA 19103
Baltimore,	permit. Pages 1 a Department of He Importent: If item any injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)		ALOM TAGUDAS 05/:	Date 20c. ROS	EDALE, MD
altii	permit. Pages Department of Importent: If is any injury or o		21. Signatur 1 Funeral Service Licensee	ACHIM ANS	F SFARD Name and Address of Facility SO	LEVINSON	& BROS., INC.
8	89789		Kolito/ du	89	OO REISTERSTOWN	ROAD - PIKE	
	Physician		29a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	that caused the death. Do not entre en each line.	er the mode of dying, such as cardia	correspiratory arrest,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Oue to (or as a consequence of):			
	ed sit	iner	cause Enter Underlying	ue to (or as a consequence of):			
,0	te be executed ysician and ne burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
09289	cate by physic the bu	dicai	d				
.O. Box 6	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
9	es that the de igned by the a be detached f	by Ph	Part II. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?
ord	w require been sign	ted	Depression, th	pothyrolalom	1	1 🗆 Yes	2 3 Probably 4 Unknown
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Vital		Be C	25. Was case referred to medical examiner?			eath (Check only one)	
of	등 무등	은	1 ☐ Yes 2 ☐ Hospita	1 ☐ Inpatient 2 ☐ ER/Outpatier Date of Injury (Month, Day Year) ER/Outpatier 28b. Time o	f 28c. Injury at Work?	Home 5 Residence 28d. Describe how in	
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۵	Hospital of the spiral of the	edical Ce	(Check only 2 Medical Examiner: O	To the best of my knowledge, deat in the basis of examination and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cause surred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	thin 2-	Med	29b. Signature and little of certifies	d marker stated.	29c. License number		Date signed (Month, Day, Year)
	To To		\sim \sim \sim \sim	X m	033947		5/10/2006
1	T		30. Name and address of person who complete	cause of death (I) 23g (Type,	Print) In Le		
	St.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	and a		
	Regist		MAY 1 2 2006	inter it proses			

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . 2006 SCHAUB 7:43 PM **Physician** EDERICK WILLIAM 6 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Rehabilatation Extended Care N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 → M 2 □ F Months Hours Vrs DEC. MD. 218-07-6505 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location t0a. State 10b County r then "naturel", or Items 23s or 28s-f show the Medical Examiner must be confilled at 1 Yes 2 No Director BALTIMORE **ESSEX** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 KELSO DRIVE APT C 21221 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2□ No 1941— If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PRESSMAN NEWSPAPER 11TH 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flik Department of Health and Menial Hy Important: If item 27 Ie marked oth eny injury or other traumatic even Be GEORGE SCHAUB ANNA STRAUSS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS SCHAUB/WIFE 8620 KELSO DR., BALTIMORE, MARYLAND 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 5/10/06 BALTIMORE, MARYLAND Important: eny injury conce. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Part Elter the disease shock, or heart failure. List Immediate Cause (Final Dementia Multi-Interction **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physician and for use es the burial-transit The law requires that the death certificate ba executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No this certificate 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ^oL 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pendina 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours a 1 🕊 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street. 10 North MD COLVIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year 20 PM Month Physician 2 SIGAI 5 2006 MAY DONNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE JOHNS HOPKINS BAYVIEW | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB. 5,1940 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** ARKANSAS 1□M 20F Yrs. 217-80-8392 Director 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b Counts r than "natural", or Iteme 23a or 28a-f show the Medical Examinar count be notified at 1 ☐ Yes 2 ▼No COLGATE Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 7626 GOUGH STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiane. OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event once. Be UNKNOWN SAM STOKES ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7626 GOUGH STREET BALTIMORE, MD 21224 DAUGHTER DONNA GRANT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/2006 BALTIMORE, MARYLAND METRO CREMATORY 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Sixeture of Funeral Service Licenses 6224 EASTERN AVENUE BALTIMORE, MD 21224 23a. Patr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NON SMALL CELL LUNG CARCINOMA STAGE 3 marth disease or condition resulting in death) /Medical Due to (or as a consequence of): CHEONIC OBSTRUCTIVE PULNOGRY UNKNOW DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit A YEARS DISEASE COLONARY ARTERY resulting in death) Last Due to (or as a consequence of): 2-3 months Completed by Physician/Medical HEMORAGIC METASTASIS BRAIN IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🕅 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown TRACT INFECTION URINARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **X**No 1 Yes 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death

Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760, nding physician Division of Vital Records, P.O. certificate ours after death. ieral Director: After this certific filled in by the funeral director.

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Certification: To Medical

To the Hospital o within 24 hours at To the Funeral D

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State Registrar 29b. Signature and title of certifier whatica,

5 Pending

investigation

6 Could not be determined

1 Natural

2 Accident

3 Suicide 4 | Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

DO57427

29d, Date signed (Month, Day, Year)

BALTIMONE, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pagiv Thals
31. Date filed (Month, Day, Year) 4940 EASTERN Thakkas

2 2006 MAY 1

AVENUE 32 Registrar's Signature

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistreAmend Item #2 Per Phy G855 5 Agrificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3:15P 20052006 May 4, Donald Franklin Thompson 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1**X** M 2□ F Yrs 723-14-7572 76 6/10/1929 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7412 DownHill Run 21702 USA12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1∑Yes 2 □ No
If Yes, Give
Year or Dates:5 1 - 5 3 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carman & O Railroad В 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alfred F. Thompson Arbutus Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7412 DownHill Run Frederick, MD 21702 Mary E. Thompson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Neurial 2 Cremation 3 Removal from State 5/6/2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cem. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service License 106 East Church Street FrederickMD 21701 Approximate Interval Between Onset and Death 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final day Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Page Department of Importent: If any Injury or

Physician

/Medical

Examiner

10a. State

Funeral

Director

or 28a-f show

Director

Completed by Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

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Baltimore, Maryland 21215-0036

P.O. Box 68760,

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Division of Vital

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical es the attending | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. attending Physiclen: 25. Was case eferred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: 30 DOA 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Atter Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident by the Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide within 24 hours afte To the Funerel Dire Hospitel or Contifying Physician: To the best ut my knowledge, death consumed at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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of death (Item 23a) (Type, Print) 30. Name and address of pers

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State Registrar

			1 - For State Registrar	State of Maryla		artment of Hea			ene . № 2 0 0 6	15029
	V 38 - 10 - 10		1. Decedent's Name (First, Middle, L.	-			2	Date of Death Month	Day Year	3. Time of Death
7	Physici /Medic		ROMEO	THIVIERGE	JR				Day Year 2006	17:45 M
A.T	Examir		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Town, or Lo	cation of Death		4c. County of Dea	th
			GOOD SAMARI			BALTI			N/A	
3	Funeral			. M	i. last birthday) Yrs.	If Under 1 Year If Months Days F	Hours Min.	. Date of Birth (Month, Day, Y	(ear) 9. Bird	hplace (State or Foreign buntry)
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	land ow		10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits
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	er dez	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
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Maryland 21215-0036	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las			18	3. Mother's Name (i		·	
<u></u> ₹	ould Men narke	은	Romeo J. Thivie	<u> </u>	10-11			i Ottens		Tie On de l
Mar	12 sh h and 7 Is n traun		19a. Informant's Name/Relationship			ing Address (Street and White Aver				
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-f show my Injury or other traumatic event, the Mucical Exportment be multiled at once.		21. Signature of Funeral Service Lice			2. Name and Address of				
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ą.			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de	ath. Do not en	ter the mode of dying, s	such as cardiac or i	espiratory arrest	t,	Approximate Interval Between
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Вох	eath certific attending p for use as I	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		Ectopic pregnancy			23d. Date of de	
	the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
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•	12		30. Name and address of person wh	completed cause of death (It	em 23a) (Type	, Print)				
	10		HAMID SADEGHIA	N, 5601 Lech 1	Raven E	BLVD. , BAL	TIMORE,	MD 21	239	
		ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	male I				
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Examin		4a. Facility Name (If not institution, give the HOWARD COUNTY G. S. Social Security Number 6. Sex	ENERAL HO	In yrs. last birth	day) If Under 1 Year	T CITY,	MD	4c. County HOWAI	RD 9. Birthplac	ice (State or Foreign
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ler death with the Marylan Items 23a or 28a-f ehow Ther must be notified at	Funeral Director	Maryland Howard 10e. Street and Number 9966 Oaklea Cou 11. Marital Status 1 Never Married 2 Married			10f. Zip Code 10f. Zip Code 13. Was Decedent of H If Yes, specify Cube	ispanic Origin? (In, Mexican, Pue	Specify Yes or No-	10g. Citizen of V USA	What Country ee - American ck, White, etc	n Indian
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or Items 23s or 28s-f show sumatic event, the Medical Examiner must be notified at	Be Completed by F	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) 011ie Smith	If Yes, Give Year or Dates:		1 □ Yes 2 ⅓ No Decedent's Usual Occup Give kind of work done life. DO NOT use retired Baker Mar	during most of wo	ame (First, Middle,	16b. Kind of Bu	AMER	ICAN
permit. Pages 1 and 2 should I) Department of Health and Mention Important: If item 27 is marken eny injury or other traumatic e ance.	То	19a. Informant's Name/Relationship (Ty Aglathia Thomps			Mailing Address (Street 404 Black	and Number or F	Rural Route Numbe			
thent of Hertant: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens:			Disposition (Name of crematory or other places Son Town C	h. May			New Ma	arket, M
Physician /Medical Examiner	dical Examiner	23d. Part1. Enter the disease, or comples shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused th	epec consequence o cutte consequence o	o nepta negycenu	erty Ro		rest,	lr	Approximate Interval Between Onset and Death
that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	,			te of delivery onth D	y Day Year
ne lew requires that the has been signed by ge 2 should be detact	Completed by Ph	Part II. Dther significant conditions con	ntributing to death but	not resulting in	the underlying cause giv	en in Part I. 7 in Color	U 1□Y	es 28 No	3 Probat	cause of death? bly 4 Unknown sy findings available ipletion of cause of
sician: The le certificate has rector, page 2	Be	25. Was case referred to medical examiner?	dospital:	0.7.50.00 i	Policet 27 DOA Oth	00	1 ☐ Yes eath (Check only o	rmed? 2 XNo	death? 1 ☐ Yes 2	2□ No
To the Hospital or Attending Physician: The lew requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending prompietely filled in by the funeral director, page 2 should be detached for use as	Certification: To	27. Manner of Death L Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) 28b. Ti	me of 28c. Injury	4 LI Nursing		now injury occur	red	
the Hospite in 24 hours the Funeral ipletely fille	Medical C	(Check only 2 Medical Exami one)	sician: To the best of ner: On the basis of e and manner state	xamination and	death occurred at the till for investigation, in my continues	me, date and place opinion, death occ	curred at the time,	date and place,	and due to ti	the cause(s)
7 × × ×	2	29b. Signature and title of certifier	_m_	up (lice co.)	29c. Licens	-7 7 1	/)	May) 21029
Y		30. Name and address of person who co	22. Registrar	810	Type, Print) Sc	er Lan	e clau	usille	. VNY	21029
Regist		MAY 1 2 2006	Bleton	1. A	noute					

DHMH 17 Rev 1/2001

			For State Registrar		State	e of Ma	ırylan				lealth <i>Death</i>		lental Hy	/giene	5 U	06	15	031
			1. Decedent's Nam	e (First, Middle	, Last)					-			2. Date of De				3. Time	of Death
	Physici /Medi		Anna Tr	ageser									Month	P	L	ZOX	X0 6	15A
	Examir		4a. Facility Name (, give street and	d number)			4b. Cin	, Town, o	r Location	of Death	7-10-11	40	. Count	y of Death	h	
			Augsbur	g Luth	eran Ho	me			Lo	chern	1			В	alt:	imore	2	
	Funeral		5. Social Security N	lumber	6. Sex		(In yrs.	last birthday) If Und Months	er 1 Year Days	If Under	r 24 Hrs. Min.	8. Date of Bi	rth)	9. Birth	nplace (Stat	e or Foreign
	Director		212-12-		1□M 218	J F	97	Yrs.	IVIOTICIA	Days	110013	With 1.	Nov. 7	, 19	08		ryland	l
7	pu *		Usual Residence of	f Decedent 10b. County		1	10c Cit	ty, Town or L	ocation								10d Incido	City Limits
X	lanyla sho	2		,					OCATION									es 2X No
(1)	the Maryland r 28a-f show codiffed at	ect	MD 10e. Street and Nu	Baltin	nore		Lo	chern	106.7	ip Code				10- 0		What Co		
0	with a or	늅			a Dood									•			unity?	
18	death with the Maryland ms 23a or 28a-f show	by Funeral Director	6811 Ca	шрттет		Decedent E	ver in II	S 13		207	lienanic Or	rigin? (Sp	noity Vos or N		S.A.		rican Indian,	
1=	ē # #	F	1 Never Marr	ied 2□ Marri	Arme	ed Forces? Yes 2		.0.	If Yes, sp	ecify Cuba	an, Mexica	in, Puerto	ecify Yes or No Rican, etc.)			ck, White		
1 036	urs aft		3 Widowed	_	If Yes	s, Give or Dates:			1 🗆 Yes	No No	Specify	<i>'</i> :			Specil	fy: V	Vhite	
20	within 72 hours after ene. then "neturel", or ite he Med Eal Excente	Completed		15. Decedent	's Education	. 0		16a. Dece	edent's Us	ual Occup	ation			16b. K	and of B	lusiness/l	ndustry	
7 2 2	thin 7 9. 9n "n	ple	Elementary/Seco	, , ,	t grade comple	ege (1-4or 5-	+)	life.	DO NOT	use retired	during mos d)	st of work	ng					
213	filed with Hyglene ther the	No.	12th g					Secr	etar	y				In	sura	ance		
P	be file tal Hy d oth	Be (17. Father's Name	(First, Middle, I	Last)						18. Moth	er's Name	(First, Middle	, Maiden	Sumar	me)		
<u>a</u>	should be filed with and Mental Hyglene. marked other the umatic event, the	ဥ	Albert	Ay							Katl	herin	e Acke	rman				
ー Anng で Maryland 21215-0036	es 1 and 2 should E of Health and Ment if item 27 is marked r other treumatic e		19a. Informant's Na	ame/Relationsh	nip (Type, Print))		19b. Mail	ing Addre	ss (Street	and Numb	er or Rura	al Route Numb	er, City o	or Town	, State, Z	ip Code)	
2	and ealth m 27	13	Anne Go		lece		1	3413	Shar	non	Drive		1timor			21213		
ore	of H of H if iter	1	20a. Method of Disp		3 □Removal f	from State	0	Place of Disp cemetery, cre	matory or	other plac			Date	20c. L	ocation	- City or T	Town, State	
altimore,	Pag ment ent: ury c		° 4 □ Donation	5 Other (Sp	pecify)		Ba.	ltimor			-		1-06	Bal	timo	ore,	MD	
Balt	permit. Pages Department of I importent: if its any injury or o		21. Signature of Fu	1 2-							ss of Facili	1111	ler-Di					, Inc.
	40.244	\vdash	236 Bohl Eblor	- Cercu		hat saves d	the deat						Baltim		MD	212		
			23a. Part1. Enter the shock, of hea	/	only one cause	on each line	9. •	II. DO NOT GE	iter the mic	ı. //	y, such as	s cardiac c	л гөзрігацогу а	irrest,			Approxim Interval E Onset an	Between
	Physician /Medical		Immediate Cause disease or condition resulting in death)	ก	_ a	6011	ity	<u> </u>	rspe	CIL	ied						·	
	Examiner		,		Du	e to (or as a	consep	uence of):	- ' -	7.	48							
		ē	Sequentially list co	nditions,	b	e to (or as a	consequ	uence of):	0 1	M	ve					_		
	uted I Insit	dicai Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	riying injury														
Ć.	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) I	Last	C. Du	e to (or as a	conseq	uence of):										
8760,	e be /sicia e bur	cai			d													
68		edi																
Box	The law requires that the death certific te has been signed by the atlanding p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes	s, outcome o	of pregna		75-44-1-						23d. Da	te of deliv	very	
	deat e atte	icia	in the past 12 1 Tes 2	No	4□P	Pregnant at t			⊒Ectopic ¡ ⊒ Other (s						Mo	onth	Day	Year
P.0	that the de led by the a detached f	hys	9 🗆 Unknown		900	Jaknown			_				-					
Š	res tha igned be del	by P	Part II. Other signif	icant conditio	ns contributing	to death bu	t not resi	ulting in the u	ınderiying	cause give	en in Part I	l.	23e. Did t	tobacco (use con	tribute to	the cause o	f death?
pro	w require been si should b	be led											1 🗆	Yes 2	□No	3 Pro	bably 4 [Known
၁	law r	Completed											24a. Was		24b.	Were aut	opsy finding	s available
ă	rsician: The law s certificate has t lirector, page 2 s	E O											autor perfo	omed?		death?	No No	Cause of
ta	ian: ntifica	Be	25. Was case reference examiner?	red to medical							26. Place	e of Death	(Check only					
<u></u>	Physician: r this certifica ral director, p	2	1 ☐ Yes 2 ☑	No	Hospital:	1 🗌 Inpatien	t 2 🗆	ER/Outpatie	nt 3□ D	OA Othe	9r: 4□ Ni	ursing Hor	ne 5 Resi	dence	6 🗆 Oth	ner (Speci	ify)	
0	ding PI h. After th funeral		27. Manner of Death	h 5 🗌 Pending		Date of Injury Month, Day	Year)	28b. Time o	of	28c. Injury Work	/ at </td <td>2</td> <td>28d. Describe</td> <td>how inju</td> <td>y occur</td> <td>red</td> <td></td> <td></td>	2	28d. Describe	how inju	y occur	red		
.0	Attending r death. actor: After by the fune	atic	2 Accident	investig	ation			,,	М		Yes 2 🗆	No						
Division of Vital Records,	r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ot be ned 28e. P	Place of Injur	ry - At ho	ome, farm, st	reet, facto	ry, office		2	28f. Location (. City or To			er or Rui	al Route No	ımber,
Ω	itel o irs afi rei Di led ir																	
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	Medical	29a. Certifier (Check only one)	Certifying 2 Medical E	Physician: To examiner: On the	o the best of he basis of e manner stat	examınai	wledge, dear tion and/or ir	th occurred evestigatio	d at the tim n, in my op	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) date and	and ma place,	anner as : and due !	stated. to the cause	9(s)
	o the o the omple	Me	29b. Signature and	title of certifier	A.				29	c. License	number			29d. Da	te signe	d (Month	Day, Year)
	F 3 F 8		NOIL.	mal 1	Willia				1	1056	721			MA	Y	Q	700	(0
	0		30 Name and add	ass of same	our complete	nauen of d-	nth (lan	22a) (T -	Print'	1731	7			14/1	'/	0	w	4
	U		30. Name and address	pos or person v	Discompleted	Cause of de	aun (item	23a) (Type,	Day 1	- 110	dil	AI	enue	P.	art	me	me Mi	D
	Sta	te	31. Date filed (Mon	th, Day, Year)	1(0)	2: Registrar	r's Signa	ture 1	an	- DE	yvvi	1104	ruce	100	ull	110	1 1 1 Y	
	Registr		14.6	V 1 0 2	200		H	Mag	1.1									

DHMH 17 Rev 1/2001

			For State Registrar	of Maryland /	-	rtment of H <i>tificate of I</i>			giene Reg. No.	006	15032
	Physici		1. Decedent's Name (First, Middle, Last) Mary E. Tolodzieck	i				2. Date of Dea Month May 9,	Day)6 Year	3. Time of Death 9:30a M
	/Medic Examin		4a. Fecility Name (If not institution, give street and	number)	,		r Location of Death	1	4c. Co	ounty of Death	1
	Funeral Director		3701 Northpoint Ro. 5. Social Security Number 6. Sex 1 M 2 M 2	7. Age (In yrs. last		Dundall If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 20		9. Birthg	re Co. place (State or Foreign nty) Carolina
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loc	ation					0d. Inside City Limits
	Ba-fsl	Director	MD Baltimore Co	Dund	lalk						1 ☐ Yes 2 Mo
	th with the 23a or 2 is the ris	al Dire	10e. Street and Number 3701 Northpoint Ro	ad Lot 83	3	10f. Zip Code 21222			10g. Citize US	on of What Coul SA	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exertified 1 once.	by Funeral	1 Never Married 2 Married 1 Yes,	ecedent Ever in U.S. Forces? es 24 No Give or Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify Whi	etc.
Maryland 21215-0036	in 72 hou n "netura Neolical E	Completed	15. Decedent's Education (Specify only highest grade complete	e (1-4or 5+)	6a. Deced (Give I life. D	ent's Usual Occup kind of work done of NOT use retired	ation during most of work f)	ing		of Business/In	
212	ed with ygiene yer tha	Com	7 N	. 1	Wait	ress				auran	
and	id be fill ental Hy ked oth ic even	To Be	17. Father's Name (First, Middle, Last) William Bazemore				18. Mother's Name	e (First, Middle,	Maiden Su	umame) 🖽 🕡	لدستنه
lary	2 should and Men Is marke	F	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	Address (Street	and Number or Run	al Route Numbe	r, City or T	Town, State, Zip	Code)
	1 and 2 Heelth a em 27 Is ther trau		Barbara Mincher - Da	aughter 3	701	Northpo	int Roa	d Lot_	83 20c Loca	tion - City or To	own State
mor	Pages nent of int: If it		1 ⊠ Burial 2 □ Cremation 3 □ Removal fre '4 □ Donation 5 □ Other (Specify)	0000	etery, crem	atory or other plac				Burn	
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee		12	Name and Address	ss of Facilin Rac Ialk Ave	zorows	ki F	unera	Home, PA
	Pnysician /Medical		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	Lyng cance	и	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
P	Examiner		Sequentially list conditions h	to (or as a consequen-	Ce 01).					-	yes
-	ted f	Examiner	fany, leading to immediate Due cause. Enter Underlying Cause (1) that initiated events c.	to (or as a consequen-	ce of):						22
68760,	ifficate be executed g physician and as the burial-transit	edicai Exa	resulting in death) Last C. Due	to (or as a consequent	ce of):						
P.O. Box 68	Attending Physicien: The law requires that the death certifics r death. r death. ector: Affer this certificete has been signed by the attending pt by the funeral director, page 2 should be detached for use as to	Physician/Med	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal de egnant at time of death nknown	ath 3	Ectopic pregnancy Other (specify)			230	d. Date of delive	ery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing t	o death but not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did to			ne cause of death?
Il Records,	The law requir cete has been si page 2 should	Completed						24a. Was a autop perfor 1 Yes	sy	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Vital	sician: Th certificete irector, pag	Be c	25. Was case referred to medical examiner?	Charting of the	/Outpatient	Other	26. Place of Deat				
Division of	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Certification; To	27. Manner of Death 28a. Da		b. Time of Injury	28c. Injun	4 □ Nursing Ho	ome Jesid 28d. Describe h			у)
Divis	l or Atte after de Directo I in by th	ertific	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home uilding, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Rura	al Route Number,
	To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and n	the best of my knowled e basis of examination nanner stated.	dge, death and/or inv	occurred at the tin estigation, in my of	ne, date and place, pinion, death occurr	and due to the cred at the time, c	cause(s) ar date and pi	nd manner as s lace, and due to	tated. the cause(s)
	To th withir To th comp	¥	29b. Signature and title of certifier			29c. License		2		signed (Month,	Day, Year)
	٨		30. Name and address of person who completed of	auca of death (from 00	la) /Tuna 5		5377		SINI	100	
_	\		Dr Jew Wu Mid.	2809 Bos	200	ST. BA	USINORE	-, m	カ	2122	4
	Sta Registr	-	31. Date filed (Month Day Year) 2006	Registrar's Signature	April	also a					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Da 1644 DOROTHY THOM PSON 08 20% MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CEMER N/A BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Year) 1 □ M 2 ₽ F Yrs. 214-16-4079 88 MD. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1046 OLD NORTH POINT ROAD UNITED STATES 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10TH College (1-4or 5+) CASHIER RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES O. THOMPSON EVA C. MAENNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK BAKER/COUSIN 7 PORTSHIP RD., DUNDALK, MARYLAND 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 5/11/06 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 21. Signal re of Funeral Service License INC. 23a. Part1 Enter the disease, or complications that should be heart failure. List only one cause of sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of) URINARY TRACT INFECTION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23d. Date of delivery 3 Ectopic pregnancy death Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? sulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 K No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ehow

or itame 23s or 28s-f ehove

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"nature!"

and the state of Heelth at sent: If Item 27 is re by or other

permit. Pege Depertment of Important: If any Injury or once.

Peges 1

Directo

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Completed

with the Maryland

2 should be filed within 72 hours after death and Mentel Hygiene.

Baltimore, Maryland 21215-0036

Examine attending physicien and for use as the burial-transit by Physician/Medical signed by the a d be detached for Completed page 2 s has Be funeral director ၉ this Certification: After

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of di
art II. Other significant conditio	as contributing to death but not res

26. Place of Death Check only one

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

Hospital: 1 🗷 Inpatient 2 ER/Outpatient 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

Injun 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 🗷 Natural

3 Suicide

4 Homicide

1 Certifying Physician: To the bast of my knowledge, death oncurred at the time, date and blace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ami

31. Date filed (Month, Day, Year)

RES-000

29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANKEDI 4940 MAY OB 2006

BALTIMORE MD 21224

Registrar

Medical



ORIGINAL

To the Hospital within 24 hours ele To the Funeret D

Hospital or Attending Physician:

death.

State

			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			ene 200	6 15034
	D 111		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medic		Ofis W.	12500				may	7 200	4 1 1 1 1 2 A M
	Examin		4a. Fecility Name (If not institution, giv				Location of Death	/	4c. County of De	eath
			4000 BELLE F.			BAlha			~/	p
ı	Funeral		5. Social Security Number 6. S	FAM 2 F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		113.			DEC. 12,	1925 1	J. Corcara
	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. fnside City Limits
	Many Fig.	ţo	Mary lass	1/1	BAILI	UIR				1 Syes 2 □ No
	r 28s	Directo	10e. Street and Number			10f. Zip Code			g. Citizen of What	Country?
	th wit	alD	4000 BELLE AUG.	V UE		2/2/5	-4916		USA	
	ems :	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Al Black, W	merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show appringuty or other traumatic avent, I'm Medical Exartical count be notified at ADRE.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give		1□Yes 2⊠No	Specify:	,	Specify:	
21215-0036	hour tural	ed b	15. Decedent's E	Year or Dates:	16a Deced	tent's Usual Occurs	ation	1	16b. Kind of Busine	
15	in 72 n" n	Completed	(Specify only highest gra	ide completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	luring most of work)	king		
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<u>a</u>	Ald be Alenta rked tic a	To B	WILLIAM WIL	sm			WILLIE	MAE	Frukon)
Maryland	end h		19a. Informant's Name/Relationship (Туре, Print)					City or Town, State	
	and 2 salth n 27 I	1	BRENDA GILES	Drugher		a. Gm	risa Are	Balo	hren, 1	emy/mo
ore	of He fiter		20a. Method of Disposition 1 Burial 2 Cremation 3		amatani crar	sition (Name of natory or other place	د اه		20c. Location - City	
Ĕ	Pag ment ant: I ury o		4 Donation 5 Other (Special	Ar	butus	Mam P	21/11	106	Baltimo	re Md
Baltimore,	Depart Depart Import any in		21. Signature of Funeral Service Lice	nsee	22	. Name and Addres	s of Facility	ATMM-	Marcii Z	nent Home
_	20 E 2 G		Derry Tur	res	B	40 RCIS	Mary IN	212 cm	15	
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent		g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Finaf disease or condition	a. Pro.	etate	Cince				107 84.13
ſ	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
		ē	Sequentially list conditions,	b. Due to (or as a conseq	usence off-					
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury		active Styl					
	ayecu al-tra	Examin	that initiated events resulting in death) Last	C Due to (or as a conseq	uence of):			-		
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9	uficat g phy as th									1)
ŏ	eath certifi attending for use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Testania programa			23d. Date of	delivery
P.O. Box	es thet the death certific igned by the attending p be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of d]Ectopic pregnancy] Other (specify)			Month	Day Year
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Ś	es th igned be de	۵	Part II. Other significant conditions	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		1	to the cause of death?
ord	w require	ted				· · · · · · · · · · · · · · · · · · ·		1 Ves	s 2.☑No 3□	Probably 4 Unknown
Division of Vital Records,	law lasb	Completed						24a. Was an autopsy	prior t	autopsy findings available to completion of cause of
<u> </u>	cate peg	Co						perform 1 ☐ Yes 2	ed? death □No 1□Y	
Σ ξ	iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		. ac no. Othe		h (Check only one)	
ō	Phys this ral dii	2	1 ☐ Yes 2 Ø No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatien 28b. Time of	(3LI DOA	4 Nursing Ho	ome S Resider 28d. escribe how	nce 6 ⊡Other (S	pecify)
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isi	Atten deal ctor: y the	fica	3 Suicide 6 Could not b	e 28e. Place of Injury - At ho	ome, farm, str		355.0 32			Rural Route Number,
á	al or a effer	Certification:	4 Homicide	building, etc. (Specif	v)	,		City or Town,	State)	
	To the Hospital or Attending Physician: The law requires thet the death certif within 24 hours effer death. To the Funeral Director: Affer this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as		29a. Certifier (Check only 2 Medical Example 1	rysician: To the best of my kno	wledge, death	occurred at the tim	e, date and place,	and due to the car	use(s) and manner	as Stated,
	the H nin 24 the Fi nplete	Medical	0110)	niner: On the basis of examina and manner stated.	uon and/or in					
	To T Com	Σ	29b. Signature and title of certifier	,		29c. License		29	d. Date signed (Mo	
	9		- I hilly 10	~~		D94.	251		5/10/06	
2	0		30. Name and address of person who	completed cause of death (ften	- 14 ·	- 1	Balton	001	2001	
1		• •	31. Date filed (Month, Day, Year)	/VII) Senistrar's Siona		tow Street	119 (t)m	eve Wid	917-01	
	Sta		31. Date filed (Month, Day, Year) 20	\$2. Registrar's Signa	400	W. C.				
3	Registr	a.								

8 P Maryland 21215-0036 ROBER. WIL SON

Box 68760,

Division of Vital Records, P.O.

the Hospital or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar PHY C855-512/96 CF Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 7:18PM B KOBERT WILSON 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KALTIMORE GICHRIST lowson ENTER If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)

5/8 2-5-1911 ENNSYLUANA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 ☐ M 2 ☐ F 95 218-12-7613 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 Ne Director mD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2819 OPPA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. "natural", or Iteme 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 24 No Specify Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR RENDIX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be in BRUCE BAKER ESTHER and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If item 27 le m eny injury or other treum once. (1) BALTIMORE, MO JUPPA M. 21234 WILSON - WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date may 12 Camelery, crematory or other place)

NEWEY

MEMOCIAL GARDENS 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) I IMONIUM MO 8800 HARFORD ED 21. Signature of Juneral Service Licensee PARKUILE, MO 21234 CHAPEL FUNERAL 23a. Part. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode as cardiac or respiratory arrest, ASPIRATION PNEUMONIA Immediate Cause (Final disease or condition resulting in death) **Physician** weeks /Medical Due to (or as a consequence of) Examiner SEVERE OROPHARYNCEAL DYSPHÁGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last attending physician and for use es the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 'AMCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 \ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospice 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannar of Death 28b. Time of Certification: After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 9,2006 520 car who completed cause of death (Item 23) (Type, Print) 6601 N. CHARLES STREET addre

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

TOWSON MD ZIZOY

			For State Registrar	State of Mary		epartment of H Dertificate of I			giene	06	15036
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	th		3. Time of Death
	Physicia		William T. War	field Sr.				Month 5	Day	2006	1:55 AM
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	(4c. Cour	nty of Death	
			St. (Ignes H	05PH41		Balt	more,	MD		n/a	
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3-27-1	Year)	9. Birthpl Count	ace (State or Foreign
	Director		212-40-3013 Tusual Residence of Decedent		63 Y	5.		3-2/-1	943	Mar	ýland
	and ow		10a. State 10b. County	10	c. City, Town	or Location				10	d. Inside City Limits
	Mary I sh	to	Md Baltin	ore	Reis	sterstown					1 ☐ Yes 2 ☒ No
	or 28e	irec	10e. Street and Number			10f. Zip Code			10g. Citizen d	of What Count	ry?
	th wit	aiD	100 Brookebury	Drive		211.	36		USA		
	r dea	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. R	ace - America	
36	or It	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2X No If Yes, Give		1 ☐ Yes 2 ☐XNo	Specify:		Spec	ity: Afr	ican-
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show lical Examinat must be notified at	d be	15. Decedent's Ed	Year or Dates:	162 [Decedent's Usual Occup	ation		16h Kind of	AM 6	rican
15	in 72 n "na Nedic	Completed	(Specify only highest gra-	de completed)	(Give kind of work done of the contract of the	durina most of workii	ng	TOD. TAILG OF	563116334116	ootiy
212	d within giene. ir than "	Ho	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Cra	ane Opera	tor		Bethl	ehem	Steel
	be filed tal Hygie d othar evant, II	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sum	ame)	
<u> a</u>	should b nd Menta markad umatic e	10	Rev. Isodore Wa	rfield Sr	•		Lena Wa	rfield			
Maryland	O1 G M M		19a. Informant's Name/Relationship (7	ype, Print)	19b. I	Mailing Address (Street	and Number or Rura	l Route Numbe	r, City or Tou	m, State, Zip	Code)
_	as 1 and 2 of Health litam 27		Gary W. Warfiel	d/Son	100) Brookebu	ıryDr.,	Reiste	rstow	m, Md	21136
Baltimore,	Pages 1 nent of H int: If ita		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □	Removal from State	cemetery	Disposition (Name of crematory or other place	(e)	ate		n - City or Tov	vn, State
ţ	t. Pa rtmen rtant: njury		' 4 □ Donation & □ Other (Specify		Arbuti	is Memoria			alto.		Ito Co
Bal	permit. Pages Department of Important: If i any injury or once.		21. Signalurs of Funeral Sepvice Licen			9200 Lil				of Ba town,	Ito. Co. Md 2113
		1	232 Part 1. Enter the disease, or companies shock, or heart failure. List only	cations that caused the	death. Do no	t enter the mode of dyin	g, such as cardiac o	r respiratory an	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Rohable	mT wiy	12 loft Ver	trizle su	shie de	efin	to	Onset and Death
	/Medical		resulting in death)	Due to (or as a co	ensequence of):	1.	20110	13,000	Juri	Lugs
	Examiner		Sequentially list conditions,	b. End St	age 1	Left Ver Lenal dis	easeon	dixly	515		years
11	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ons viuence of):	1				/
1	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a co	ensequence of	mellitus	type				years _
,60	be exician buria	a E				,,					V
68760	ficate physics the	edicai	`	d					04		
Box (The law requires that the death certificate be execuled to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. (Date of deliver	у
ă	death e atte d for	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 ☐ 4 Pregnant at time		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	'			Month	Day Year
P.0	at the de by the a stached	hys	9 Unknow	9 Unknown							
	res that signed to be det	by P	Part II. Other significant conditions of	entributing to death but no	ot resulting in t	he underlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to the	e cause of death?
Records,	w require been signature							1 🗆 Y	es 200 No	3 Proba	ıbiy 4 ∏Unknown
eco	has be	ple						24a. Was a		prior to com	sy findings available inpletion of cause of
<u>m</u>	10	Completed						perfor 10X Yes	med? 2 ☐ No	death?	2□ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11			26. Place of Death	(Check only or	ne)		
of	Physician: r this certificatal director,	2	Tes 2 No	Hospital: 1 Inpatient	2 ER/Outp		4 Nursing Hor)
u C	ding Physician: h. After this certific funeral director,	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Cate of Injury (Month, Day Ye	ar) 28b. Tir	ury Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occ	urrea	
15.	Attending r death. sctor: After	Ical	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury	At home, farm	n, street, factory, office		28f. Location (S	treet and Nu	n <i>ber or Rur</i> al	Route Number.
Division	after after Dirac	Certification;	4 Homicide determined	building, etc. (S	ipecity)	, discol, lastory, omos		City or Tow			
	Hospital or 24 hours afte Funeral Dir tely filled in I		29a. Certifier Certifying Ph	/sicien: To the best of m	y knowledge,	death occurred at the tin	ne, date and place, a	and due to the o	ause(s) and	manner as sta	ited.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	iner: On the basis of exa and manner stated.	amination and	or investigation, in my o	pinion, death occurre	ed at the time, o	late and plac	e, and due to	the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	and manner stated. Sompleted cause of death 32. Registrar's		29c. Licens	e number	/ 2	29d. Date sign	ned (Month, E	Day, Year)
			Mulina TE	surk 6)	DOO	36765		5/5	12006	1
	-		30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print)					
			MELISSA BUICH	mn 900	CATON	VAVE BA	ALTIMORE	E, MDE	262	9	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Hegistrars	Signature	where		,			

DHMH 17 Rev 1/2001

WARFIELD, WILLIAM T.

06-03073

Please Type or Print in Black Indelible Ink

		Regi			ate of Maryla	and / Dep <i>Ce</i>	artment of ertificate of	Health a Death	nd Mental	Hygiene		000	6 1506
Phys Medical Ex	sicia amin	ner			nes		right			2. Date of Do Month May 6, 2	Day	Year	3 Time of Death 2351 hrs
					n, give street and nu w Medical Cen		0	b. City, Town, Baltimore	or Location of De			ounty of Death	4
Fune Direc		21.	Security 5 -7 4 -	-7038	6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye			Birth(MM/DD/	YYYY) 9. Birt Foreig Cou	hplace (State or number) Mary luna
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any	edical Examiner must be notified at once,	10a. 10e. 11 M. 11	State Street and Nu arital Status Never Marria Widowed Decedent's Edmentary/Second ather's Name Commentary/Second ather's Na	mber A 0 ed 2 Ma 4 Divo ducation (Spec ondary (0-12) (First, Middle, eme/Relationsh C + C position Cremation Other Spe	Armed For 1 Yes orced of Yes, Give Yea or Dates: If yes, Give Yea or Dates Yea or	edent Ever in U proes? 2 No le completed) 4 or 5+) A daughte m State K	13. Was If Ye 1 1 16a Decedent during mo	Decedent of H s, specify Cuba Yes 2 N s Usual Occup st of working lif O C Address (Street	an, Mexican, Pue o specify: ation (Give kind of e DO NOT use of 18.Mother's Nam et and Number of complete and Number of complete and Number of complete and Number of	Specify Yes or Norto Rican, etc.) of work done etired) me (First, Middle, Argue Nu Paula Royle	10g. Citizen 1	of What Coun US Race - Americ White, etc. Cify: of Business/In DS p T name) Town, State, O. md, tion - City or T. d auls/	10d. Inside City Limits 1 Yes 2 No try? A lan Indian, Black, 3 a R dustry Zip Code) 2 1 2 34 own, State www., Md.
Chysicia (Medica) (Me	aminer aminer	Seque if any, cause (Disea events	ive Cause (F dition resultin Initially list con leading to im Enter Under se or injury th resulting in d	Final disease g in death) aditions, mediate dying Cause at initiated	a Narcotic Due to (or as a c b. Due to (or as a c c. Due to (or as a c d. AMENDED	used the death. cs and consequence of consequence of consequence of consequence of term#23a,	Do not enter the caine into	mod of dying	such as cardiac	or respiratory and	Hone est, shock, o	Paule r heart	nd 21229 Approximate Interval Between Onset and Death
Records, P.O. Box 68 The law requires that the death certil ficate has been signed by the attending page 2 should be death-deformed.	pleted by Physician	23b. Wa part II.	as decedent p st 12 months? Yes 2 No	9 Unkno	1 Live bird 4 Pregnar 9 Unknow as contributing to d	nt at time of dea n	2 Fetal th 5 Other		Ectopic pregniven in Part I.	23e Did to 1 Yes 24a Was a autop: perfor 1 Yes 2	bacco use co	ontribute to the 3 Probab	Year y cause of death? ly 4 Unknown sy findings available pletion of cause of 2 No
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certi completely filled in by the funeral director	Certification: To	27. Mar 1 2 3 3 4 29a. Ce (Check or one)	Yes 2 ner of Death Natural Accident Suicide Homicide Tiffier 1 C	5 Pending Investig Could n determinertifying Physedical Examin	28a. Date of (Month, Date) 5/6/2000 28e. Place of the control of	Injury ay,Year) Ui If Injury - At hom Home If my knowledge examination and	R/Outpatient 3 8b. Time of Injur nk ie, farm, street, f. death occurred /or investigation,	DOA y 28c Injury 1 Y actory, office but at the time, dat in my opinion,	Other Nursing at Work? es 2 X No uilding, etc. e and place, and death occurred an number	28d. Describe h unk 28f. Location (S' or Town, St Baltimore, due to the cause to the time, date a	treet and Nur ate) 6214 MD (s) and mann nd place, and	mber or Rural I	use(s)
S Regis		Lard 31. Date	e and address on Locke M	MD. Assi	completed cause of stant Medical E		•	O.C.M	ore, MD 212	01	May 7, 20	006	

			1 - For State Registrar	State of Many	-	artment of F			gienę ()	06	15038
	Physici	an	1. Decedent's Name (First, Middle, Last	•				2. Date of Dea Month May	1Day	ް006	3. Time of Death
Å.	/Medic Examin	al	Christian Rob 4a. Facility Name (If not institution, give Stella Maris I	street and number)	echowsk	i 4b. City, Town, o Timoniu			4c. County Balti	of Death	6:30A.M
	Funeral	Ů.	Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days		(Month Day	h (Year)	9. Birthpla Countr	
	Director		165-64-5695 Usuel Residence of Decedent 10a. State 10b. County	,	76 Yrs.			7/13/	729		Jersey
	a-f sho	ctor	Md How			cott Ci	ty			100	1 ☐ Yes 2 ☒ No
	with the	i Dire	10e. Street and Number	onton Dog	A	10f. Zip Code 210	4.2		10g. Citizen of V US		y?
	deeth	nera	12300 Folly Qu	12. Was Decedent Eve Armed Forces?		Was Decedent of H		Specify Yes or No-		e - America	
900	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event. In Medical Exam in armust be notified along.	by Funeral Director	1ÆNever Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	no rican, etc.)	Specif	ok, White, et v: Whi	
215-0	hin 72 h in "natu Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of we	orking	16b. Kind of B	usiness/Indu	stry
121	iled with	Com	12 17. Father's Name (First, Middle, Last)	5+	Fra	nciscan		ma (Final Middle	Relig		Order
/lanc	uld be f Mental h irked of	To Be	Stanley Wojcie	chowski				me (First, Middle, y Lisie)		ne)	
Man	nd 2 sho lth and 27 is my trauma		19a. Informant's Name/Relationship (7) Fr. Michael Kol			ng Address <i>(Street</i>) 0 Folly					/ 1 1 1 4 /
Baltimore, Maryland 21215-0036	ages 1 er nt of Hea : ff Item or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	2	20b. Place of Dispo cemetery, crea		>e)	Date 15,2006	20c. Location	City or Tow	n, State
altin	permit. Pa Departmen Important eny injury	2	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens				1	1		,	Home, PA
	20F 2 9		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the	>/\ .	<u> 1201 Dun</u>	idalk A	ve. Bal	timore	, Md	21222 Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. LUNG CANO							nterval Between Onset and Death
B	/Medical Examiner			Due to (or as a co	onsequence of):						
14	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):						
8760,-	cate be executed physicien and the burial-transit	al Exa	resulting in death) Last	Due to (or as a co	ensequence of):						
9		Medic	IF FEMALE:	0.							
.O. Box	that the death certific led by the attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of delivery inth D	ay Year
S, D	es the	۵	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.		bacco use cont		cause of death?
Vital Record	e law requir hes been si je 2 should i	Completed						24a. Was a autops	sy	prior to comp	y findings available pletion of cause of
tal F	ician: The lav certificete hes rector, page 2	0	25. Was case referred to medical				26 Place of De	perfor 1 ☐ Yes	2X No	death? 1 Yes 2	ØNo
of Vi	Physician: rthis certific ral director,	ToB	examiner? 1 ☐ Yes 2 👿 No	lospital: 1 Inpatient	2 ER/Outpatier		er: 4 🗆 Nursing	Home 5 ☐ Resid	ence 6XIOth		HOSPICE
	ding h. After fune	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occur	red	
Division	af or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, sti Specify)	reet, factory, office		28f. Location (S City or Town		er or Rural I	Route Number,
	To the Hospital or At within 24 hours after of To the Funsral Direct completely filled in by	edical C	29a. Certifier Check only one) Certifying Phy	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) and ma date and place,	anner as stat and due to ti	ed. he cause(s)
1	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens		1	29d. Date signe	1.1	ay, Year)
,	1		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type.		43725		5/1	11/06	
	6		DR. TARIQ MAHMOOD	2300 DULA	NEY VALLE		LMONIUM,	MD 21093			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 2 2006	32. Registrar's	Signature Sosa	W					

MAY 11, 2006

CHRISTIAN WOJCIECHOWSKI

			1 - For State Registrar	State of Mary	•	artment of H			ene g. No. 2006	15039
			Decedent's Name (First, Middle, Last					2. Date of Death		3. Time of Death
н	Physici		Pe	ter Fagan	Yellin			May 10	Day Year 2006	11:00P M
	/Medio Examir		4a. Facility Name (If not institution, give		101111	4b. City, Town, o	or Location of Death		4c. County of Death	
			Chesapeake Hos	pice House	2	Lint	hicum		Anne A	rundel
	Funeral		Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		111-44-91/1	M 2UF	54 Yrs.	Monaro Bayo	1100.0	DEC 18,	1951 In	diana
	and w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Manyl 1 ehc	0	Maryland Anne An	rundel	٨٣	napolis				1 ☐ Yes 2 🛣No
	156 286-	Director	10e. Street and Number	didei	Ai.	10f. Zip Code		10	g. Citizen of What Cou	untry?
	3e or	<u></u>	104 Carroll Drive	2		1.5	403			,
	ms 2:	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	USA 14. Race - Amer	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 ie marked other then "neturel", or Items 23e or 28e-1 ehow mith jujury or other traumatic event. The Medical Examiner must be instiffed at ance.	by	1 Never Married 2 Married 3 Widowed 4 Morried	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		f Yes, specify Cubi 1 ☐ Yes 2🎇 No		o Rican, etc.)	Black, White	hite
5-0	72 ho netur	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occup	pation	tring 10	6b. Kind of Business/I	ndustry
21	uthin a	ngie	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor d)			
21	ygier ygier it.	S		4	Phy	sician's	Assista		Cardiol	ogy
and	12 should be filed within h end Mental Hygiene. 7 le marked other then " fraumatic event, the Med	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	aiden Sumame)	
ž	hould d Mer nark	2	Edward L. Yellin 19a. Informant's Name/Relationship (T)		10h Maille	- Add (C44		Fagan	0	
Ma	d 2 s th en t7 le r traur		Edward L. Yellin/I						City or Town, State, Z	
	Health tem 27 other tra		20a. Method of Disposition		b. Place of Dispo	sition (Name of			7, Sarasot	
Ω U	ages ant of it: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	-	natory or other place	1	106	D 1. *	100
Baltimore,	permit. Pages i Department of H Important: If Ite eny Injury or ot once.		21. Signature of Funeral Service Latens		22	. Name and Addre	SS of Facility	Cremation	Baltimore Society o	f MD Tree
ã	Depariment Department of the partment of the p		Edward A Gree	orchik		299 Fred	erick Roa	ad Baltimo	ore, MD 21	228
			23a. Part1. Enter the disease, or compleshock, or heert failure. List only of	cations that caused the						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	TO CEEST OF SECTION.		Brain	tomo	or/Glio	61astoma	Onset and Death
7	/Medical		resulting in death)	Due to (or as a cor	rsequence of):	0,000		1/0		year
	Examiner	_	Sequentially list conditions,	D						
. 1	per list	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	rsequence of):					
Pa	xecu al-tra	Examin	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
38760,	cate be executed physicien and the burial-transit	dical	(1						
9	ufficati g phy as the	ledic								
Box	leath certific attending p I for use as i	an/N	200. Has decedent pregnant	3c. tf yes, outcome of pro		Ectopic pregnancy	u.		23d. Date of deliv	,
	e dea the att	Physician/Me	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time 9☐Unknown		Other (specify)	·		Month	Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown			(-), (-)		00 5:		
Records,	ed bed	d by	Part II. Other significant conditions con	ithouting to death but not	i resulting in the ur	idenying cause giv	ren in Part I.	1 ☐ Yes	cco use contribute to 2 X No 3 ☐ Pro	
Ö	w requir	Completed	1					-		
Rec	The lav	m m						24a. Was an autopsy performe	24b. Were aut prior to co death?	opsy findings available omptetion of cause of
Vital		e Co	25. Was case referred to medical		 			1 ☐ Yes 2	No 1 ☐ Yes	2 No
₹		0 8	examiner?	lospital:	2 ER/Outpatien	t 3 DOA Oth	ACC.	th Check only one ome 5 Residen	ce 6 Sother (Speci	zi tlocolia
10	g Physe er this	Η,	27. Manner of Death	28a. Date of trijury	28b. Time of	28c. Injur		28d. Describe how		W HUSPICE
<u>o</u>	Attending For death.	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	<i>lr)</i> Injury		Yes 2 □ No			
Division	I or Attend after death Director; /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	pital ours a eral E		29a Certifier 1 2 Certifyin Phy	To the best of our	Institutes to the					
	To the Mospital or Ai within 24 hours after of To the Funeral Direct completely filled in by	Medical		ner: On the basis of exar and manner stated.	mination and/or inv	restigation, in my o	ppinion, death occu	rred at the time, date	e and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	~0. · · ·		29c. Licens			d. Date signed (Month,	
			+ Freedu	ellsuo		UI	4858		>112/2001	6
	VQ		30. Name and address of person who co	enpleted cause of death	(ttem 23a) (Type, 1996)	Print) 1,00 Bes	to ase Ro	l. Anna	5/12/2001 cpolis, Wa	d. 21401
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 2 2	32. Registrar's S		basel)				
			WALLAC	UUU Florence	1 10 10	THE WAY				

		1 - For Amend Item Registrar		Céi	rtificate of l	Death	R	eg. No.	00	10040
Dharata	/6%	1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	Day	Year	3. Time of Death
Physici /Medi			Ada Cath	erine Zim	merman		May 6	, 2006		6:50 AM
Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. County	y of Death	
	Ų.	14410 Water Comp	any Lane			cade		Wa	shing	
Funeral				(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year)	9. Birthp	lace (State or Foreigntry)
Director		201-42-7367	1 □ M 2 💢 F	80 Yrs.			May 22	, 1925		aryland
p .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	antion					0d. Inside City Limit
aryla ehov	-	Tod. State								1 ☐ Yes 2 🛣 No
72 hours after death with the Maryland netural', or Itema 23a or 28a-f ehow dical Exacultar nutt be notified at	Director	Maryland Washing	ton	Cá	ascade					
्टे क 0 2 3	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
ath v	ra .	14410 Water Comp				21719			S.A.	
e de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)		ce - Americ ck, White,	
ori	by F	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give	0	1□Yes 2 <mark></mark> No	Specify:		Speci	y: _E	7h i + a
ural'		3 Widowed 4 Divorced	Year or Dates:	10.5				101 101 1 1 1		hite
net Ille	Completed	15. Decedent's E (Specify only highest gi		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of worki	ng	16b. Kind of B	usiness/in	dustry
within ene.	ם	Elementary/Secondary (0-12)	College (1-4or 5-	+)				Boomd	05 E	Jugatian
2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, trem		12 17. Father's Name (First, Middle, Las	**1		Cafeteria	18. Mother's Name	/First Middle			lucation
should be find Mental Hard Mental Hard Mental Hard of umatic ever	Be								110)	
Merke	은	Welty M. Stottl	9				a M. Dra			
n and	1	19a. Informant's Name/Relationship			•	and Number or Rura				,
of Health of Health of Health of Item 27 is rother tre		Maurice E. Zimme	rman (Husba	20b. Place of Dispo	THE RESERVE TO SERVE	ompany Ln				
Pages 1 end z should be liled within 7z hours after beath with the marylan neat of Health and Mental Hygiene. Int: If tiem Z7 is marked other then "netural; or liems 23a or 28a-f show and it if other treumatic event, it a Madical Exerting in all be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 (Removal from State	cemetery, crei	matory or other plac	e)		20c. Location		
men men men men men men men men men men		4 □ Donation 5 □ Other (Spec		Smithsbur	rg Cremato	ory May 1	100			, Marylan
permit. Pages Department of Important: If i eny injury or once.	l i	21. Signature of Funeral Service Lice	ensee		2. Name and Addres			Davis F		
20 E 2 9		Janes de	Davis /	NO1414 12	2525 Brad	bury Ave.	Smithsl	ourg, M	aryla	nd 21783
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused ly one cause on each line	eath. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arr	est,		Approximate Interval Between
nysician		Immediate Cause (Final disease or condition		1200	t Cer	ce			115	Onset and Death
/Medical		resulting in death)	Due to (or as a	consequence of):	`					
Examiner										
	ě	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of:						
ansl	Examiner	Cause (Disease or injury that initiated events	c							
exec en an	EX	resulting in death) Last	Due to (or as a	consequence of):						
cate be executed physicien and the burial-transit	dical		d							
g ph as th	9									
es triat trie deant certain igned by the ettending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Da	te of delive	ery
deatl	icia	in the past 12 months?	4☐Pregnant at t		Other (specify)			M	onth	Day Year
by the ached	hys	9 Unknown	9□ Unknown							
ped e	by P	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the	ne cause of death?
							1 🗆 Y	es 2 No	3 ☐ Prob	ably 4 Unknow
n sign	(4)						774	n 24h	Were auto	psy findings availabl
s been sign should be	jete						24a. Was a	270.		
has been sign	omplete						autops	med?	prior to co death?	mpletion of cause of
ete has been si pege 2 should	Completed	25. Was approximately medical					autops perform 1 Yes	med? 2 No	prior to co	mpletion of cause of
ete has been si pege 2 should	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death	autops perform 1 Yes	med? 2 2 No	prior to co death? 1 Yes	mpletion of cause of 2□ No
this certificete has been siral director, page 2 should	To Be	examiner? 1 Yes 2 No	1 Linpatier			er: 4 🗆 Nursing Hor	autops perform 1 Yes	med? 2 2 No ne/ ence 6 Ott	prior to co death? 1 Yes	mpletion of cause of 2□ No
fung Fingstram. The law required this certificate has been sifuneral director, page 2 should	To Be	examiner? 1 Yes 2 No 27. Mann Death 1 Natural 5 Pending	28a. Date of Injun (Month, Day		28c. Injun	er: 4 Nursing Hory at k?	autops perform 1 Yes	med? 2 2 No ne/ ence 6 Ott	prior to co death? 1 Yes	mpletion of cause of 2□ No
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within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Medical Certification; To Be	examiner? 1 Yes 2 No 27. Mann Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying Paragraphic Check out one) 29b. Signature and title of certifier	28a. Date of Injunction 28a. Date of Injunction 28a. Place of Injunction 28e. Place of Injunctio	year) 28b. Time o Injury ry - At home, farm, str. (Specify) f my knowledge, deat examination and/or inted.	f 28c. Injun Work M 1 1 reet, factory, office h occurred at the lin vestigation, in my of 29c. Licensu	er: 4 Nursing Hory at X? Yes 2 No	autops perfor 1 Yes 1 Check only or The Residence of the continuous of the contin	med? 2 2 No ence 6 Otto con injury occu- treet and Num. n, State) ause(s) and m ate and place,	prior to co death? 1 Yes her (Specified ber or Rura anner as s and due to	mpletion of cause of 2 No No No Route Number, tated. the cause(s)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mer 1- State of Maryland / Department of Health and Mer 27 per Dr., G855, 05/15/106dhb Certificate of Death	ntal Hygien Reg. N	2006 15041
A. Barre	Physic /Medi		1. Deglécient's Name (First, Middle, Last) Wilma Juliet Samuel Anderson 2	Date of Death Month Da	ay Year 3. Time of Death
*	Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital of Baltimore Ralfmore	J 40	c. County of Death
7	Funeral Director			Date of Birth	9. Birthplace (State or Foreign Country)
NZV.			Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	, w. y =	10d. Inside City Limits
Anderson	n the Marylan r 28a-f ehow inotified at	ţo	ND Baltimore		1 Nes 2 No
4	th with the 23s or 28	Funeral Director	2505 W. Belvedere Ave. Apt. #3 2/2/5	10g. C	itizen of What Sountry?
uel	er dea	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Sain	within 80e.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Assistant fore?	7an 6	Kind of Business/Industry Hate F Maryland
	E 8 E B S	To Be C	17. Father's Name (First, Migralp, Last) 18. Mother's Name (F Uulia	Spark	n Surname)
-	2 5 m 2 c	(Shannon Anderson Daughter 1921 Kamblewood Rd. I	Boute Number, City	or Town, State, Zip Code) ND 2/239
3	2 2 2 2 2		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cameter), crematory or other place) 5 10	106 Ba	Location - City or Town, State Thomase, MD
	Saltim permit. Pag Department Important: ? eny injury o		21. Signal fro of Funeral Service Licens Variable Addies of Entire ne Start her for Rd. P		Louritus
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ATHENOSCIENOTIC CHILDIOVASCIA Due to (or as a consequence of):	VAR D	
	Examiner				
	uted 1 Insit	Examiner	Cause. Iterat Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events		
9	58 / 60, icate be executed physicien and s the burial-transit		resulting in death) Last Due to (or as a consequence of):		
į	phy:	edical	d.		
	Hecords, P.O. BOX to The law requires that the death certifute has been signed by the attending tage 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery N/A Month Day Year
	S, P.	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
	Cord		HYPENTENSION	-	2 No 3 Probably 4 @Unknown
. !	r VITAL REC ysicien: The law is certificete hes t director, page 2 s	Completed	DIABETES MELLITUS	24a. Was an autopsy performed?	
1	ysicien: The scentificate director, pag	To Be	25. Was case referred to medical examiner? 1 Types 2 No		6 □Other (Specify)
3	ing Phr Mter thi	on: T	27. Manner of Death 1 Natural 5 Tatending (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	d. Describe how inj	
#:	DIVISION OF VITAL HECONDS, To the Hospitel or Attending Physicien: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be d	Certification:	2 Accident 3 Suicide 4 Homicide Accident f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
	Hospitel 24 hours 8 Funeral I	Medical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier 29c. License number		eate signed (Month, Day, Year)
)		BARBARA L. SANICO, MD D5/57/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANBARA L. THE CREAT WELLER CONTROL OF THE CAUSE STATES STATE	0	5/08/06
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANBANA C. THE GBMC WEINBERG CENTER, IZOD E. FAYETTE ST.,	BALTIN	M. D. 10RE, MD 21202
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

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	1 - For State Registrar	State of Maryland	•	e of Death	Re	g. No.	10046
Physician	Decedent's Name (First, Middle, Last) Decedent A A A A A A A A A A A A A A A A A A A	1			2. Date of Deat Month	Day Year	3. Time of Death 3:10 P M
/Medical	Edward A. Ad 4a. Facility Name (If not institution, give s		4h City	Town, or Location of Dea	MAY	10 th 200 6	
Examiner	SAINT AGINES			LTIMORE		N/A	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) If Unde	1 Year If Under 24 Hrs	8. Date of Birth		nplace (State or Foreign untry)
Director	212-40-3057 ¹ X	M 2□F 62	Yrs. Months	Days Hours Min	8. Date of Birth (Month, Day, Nov. 7,	1943 V	irginia
p 3	Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Location				10d. Inside City Limits
Aaryis I sho	MD Balti			timore			1 ☐ Yes 2 X No
the N	10e. Street and Number	MOTE	10f. Zip		11	Og. Citizen of What Co	untry?
South with the Marer death with the Marer terms 23s or 28s-1 et richer must be multified. Funeral Director	4603 Benson Avenue	e		21227		United St	ates
death		2. Was Decedent Ever in U.S Armed Forces?	13. Was Dece	dent of Hispanic Origin? (Softy Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame Black, White	ncan Indian,
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Deportment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exerciper must be nutified at once. To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give		No Specify:	10 (1041)		erican Ind:
Maryland 21215-0036 d 2 should be filed within 72 hours eft and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Madical Exerti To Be Completed by F	15. Decedent's Educ	Year or Dates:	16a. Decedent's Usu	al Occupation		16b. Kind of Business/	ndustry
nd 21215-00 be filed within 72 hou be tiled within 72 hou d other than "natura event, the Madical event, the Madical event, the Madical event, the Madical	(Specify only highest grade	completed)	(Give kind of wo	rk done during most of wo se retired)	rking	100. 10110 01 20011030	dustry
212 d with giene trans	Elementary/Secondary (0-12)	College (1-4or 5+)	Carpe	nter		Constru	iction
e file other vent,	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	faiden Surname)	
Vlau build b Ments Ments artice	Lemon Adcock			F	cances Jol	nns	
2 sho	19a. Informant's Name/Relationship (Typ	oe, Print)		(Street and Number or R			
e, N t and teelth om 27 ther tu	Jean Adcock - Compa		4603 Ben	son Avenue,		e, MD 21227	
Battimore, permit. Peges 1 ar Depertment of Hee mportant: If them any injury or othe	1 ØBurial 2 ☐ Cremation 3 ☐ R	emoval from State Mea	dowrddae or	ther place)		20c. Location - City or	rown, State
ti Pe	21. Signature of Juneral Service Ucense	Men	orial Park		.5-2006	Elkride,	MD
De Perm	Constitution of the state of th	0000		^{nd Address of Facility} Amb Ulphur Sprin			
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the death.					Approximate Interval Between
Physician	Immediate Cause (Final disease or condition		OCOMIA	L PNEUM	IONIA		Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a consequ	ence of):				DAYS
	Sequentially list conditions, b	A STATE OF THE PARTY OF THE PAR	Name to 111	NEUMONI	A		<i>D.</i>
executed an and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (of as a consequ	ence or).				
xecu	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
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6876(utilicate be g physicie as the bur				Control Harris			
of Vital Records, P.O. Box Physician: The law requires that the death cer this cartificate has been signed by the ettendinal director, page 2 should be detached for use; To Be Completed by Physician/W.	230. Was decedent pregnant	3c. If yes, outcome of pregnan		regnancy		23d. Date of del	•
, P.O. Box that the death ce ed by the ettendir detached for use / Physiclan/A	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of de 9☐ Unknown				Month	Day Year
P.C nat the d by t etach	9 Unknown				22a Did tab		the serves of death?
If Records, P.O. Box: The law requires that the death cercate has been signed by the ettending page 2 should be detached for use Completed by Physician/M	Part II. Other significant conditions con CHRONIC OI	BSTRUCTIVE F			-	accoluse contribute to	bably 4 Unknow
require should should		271,007,007		, , , , , ,			
Vital Record sician: The law requir certificate has been s rector, page 2 should	STROKE	nc IT			24a. Was au autops perform	n 24b. Were au y prior to death?	topsy findings available completion of cause of
Vital Fiction: The cartificate rector, pag	HEART DISE	ris E			1 ☐ Yes 2	PNo 1 ☐ Yes	2 No
Vita	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 (Inpatient 2 🗆 E	R/Outpatient 3 D	Othor	ath (Check only on	nce 6 □Other (Spe	2.6.1
on of ding Phys. After this funeral di	27. Manger of Death		28b. Time of	28c. Injury at		w injury occurred	ary)
Attending r death. Sector: After on the fune fune fill attending the fune fill attending the fune fill attending the fune fune fune fune fune fune fune fun	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division or Attending eiter death. Director: Afte tin by the fune ertification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factor	y, office	28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
Hoepita 4 hours Funerel ely fillec	(Check only 2 Medical Exemin	icien: To the best of my know her: On the basis of examinati	rledge, death occurred on and/or investigation	at the time, date and plac , in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
To the within 2 To the complet	one) 29b. Signature and title of certifier	and manner stated.	29	c. License number	99	9d. Date signed (Monti	n, Day, Year)
	Danie la ai	annathan		18608		May 10	
F 3 F 8	11/009						
7	1 1		23a) (Type Brint)		300 25-		
2	30. Name and address of person who co		23a) (Type, Print) AGINES HEA		100 CATE		

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 15043

		- For State Registrar		Certific	ate of	Death					Reg No	. 4	UU		J U 4
Physicia		1. Decedent's Name (First, Middle,L	ast)					_	2.	. Date of De Month	ath Day	Year		Time of De	
ledical Examir	ier	Robert Lee Atk	inson							April 20,	2006	I cal		0151 hrs	S
		4a. Facility Name (if not institution,			41	. City, Town	, or Lo	ocation of	Death		4	c. County o	f Death		
		University Of Maryland I	Medical Center			Baltimore	9								
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last bir	thday)	If Under 1 \	Year	If Under	24Hrs.	8. Date of E	Birth (MM	I/DD/YYYY		place (State	or
Director		unk	V			Months [Days	Hours	Min.				Foreign	ntru\ a	
	L		X M 2 F	46	Yrs.				لــــــــــــــــــــــــــــــــــــــ	Nov :	12,	1959		^{ntr} Èng1a	and
>-	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Looptio						_		—т	10d. Inside C	ity Limite
w any	- 1	Toa. State Tob. County		Too. City, Town	Of Locatio	•								1 X Yes	
aryland 8a-f sho	ь	MD		Baltimo	ore									1 X Yes	2NO
Aaryland 28a-f show 1 at once.	<u>\$</u>	10e. Street and Number		110000	244	10f. Zip Cod	le				10g Cit	izen of Wh	at Count	ry?	
th the M 23a or 2 notified	Director	1404 Kuper Pla	Ce			21230	1				USA				
with the s 23a e noti	듄	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of		anic Origi	n? (Spec	cify Yes or N			- Americ	an Indian, Bla	ack,
death or item	Funeral	1 Never Married 2 Marr	ied Armed Forces?	V	If Ye	s, specify Cu	ban, I	Mexican, I	Puerto Ri	ican, etc.)		White	etc.		
, or		3 Widowed 4 X Divorce	ed If Yes, Give Year	X No	1 .	res 2 X	No	specify.				Specify:	R1ac	.le	
ural min	효	15 Decedent's Education (Specify	or Dates:	pleted) 16a.	Decedent's	S Usual Occ	patio	n (Give ki	ind of wor	rk done	16b	Kind of Bus			
2 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5		during mo	st of working	life. [OO NOT u	ise retired	d)					
36 in 7 han dical	e e			·	(Mar	-1 4-		
Me r a	6	12 17 Father's Name (First, Middle, La	none	I.	leat (<u>utter</u>	18	3.Mother's	Name (F	irst Middle		ır Mar Surname)			
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MD 10e. Street and Number 10f. Zip Code 1230 10f. Zip Code 1404 Kuper Place 1230 10f. Zip Code 1404 Xip Zip Code 15f. Z										umbor (Pitu or Tour	Stoto	Zin Codo)		
D 2 shoul	Ĕ												i, Giale,	Zip Code)	
Baltimore, MD permit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	ŀ	Rhonda Atkinsor 20a. Method of Disposition	1/sister			cnacle				Date			City or 1	Town, State	
S 1 au file Her fr		1 Burial 2 Cremation	3 Removal from Sta		tory or othe		Cellit	etery,	'	Date	200	Location -	City Ut 1	OWII, State	
MO Page ent o		4 Donation 5 X Other Spec	_								1				
nit artm oorta	ŀ	21. Signature of Funeral Service Li	censee			me and Add								•	
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Physician	\dashv	23a. Part I. Enter the disease, or co		the death. Do n	ot enter the	mode of dy	ing, s	uch as ca	rdiac or r	espiratory a	arrest, sh	ock, or hea	ırt	Approximate	
/Medical		failure List only one cause or		4.10/										Between O Dea	
xaminer	ļ	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse												
and the same of th			b	querice or).											
	늘	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					-						
	Examiner	cause. Enter Underlying Cause	C.												
4	g	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):		-									
xecuted n and - transit			d												
760, icate be execute physician and the burial - tran	Physician/Medical	UNPENDED	AMENDED												
50, ite be hysic e bur	Je	IF FEMALE:	23c. If yes, outcon	ne of pregnancy							23	3d. Date of	delivery		-5 1
18760, rificate boing physic as the bur	2	23b. Was decedent pregnant in the past 12 months?	1 Live birth			al death	з [Ectopic	pregnanc	СУ		Month	Di	ay '	Year
× 6 h cer tendi	<u>:</u>			time of death	5 🗌 Oth	er (Specify)					- 0				
Box e death c the atten ed for us	S	1 Yes 2 No 9 Unkno	9 Unknown												-
, P.O. Box 6 res that the death cer signed by the attendible be detached for use		Part II. Other significant condition	ns contributing to death	but not resultir	ng in the ur	derlying cau	se giv	ven in Par	t I	23e. Did	tobacco	use contri	oute to the	he cause of d	leath?
es th.	d b									1 N	'es 2	√ No 3	Proba	ably 4 U	Inknown
ords, w requir s been s should	Completed									24a. Wa	as an			opsy findings	
aw r law r has b 2 sh	힐										opsy formed?		rior to co eath?	ompletion of a	cause of
Rec The The page	팃									1 🗸 Yes	s 2 1	No 1	✓ Yes	s 2	No
tal Recician: The certificate	Be	25. Was case referred to medical				26.P		of Death (Check on	ıly one)					
Vit hysici Ithis o	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/0	Outpatient	3 DOA	lc	Other 4	Nursing	Home 5	Resid	lence 6	Other:		
J of Jing Ph	Ë	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of In	ury 28c.	Injury	at Work?				jury occurre	∍d		
On tendin or: A	ij	1 Natural 5 Pendir		012	0 hrs	1[Ye	es 2 🗸	No S	ubject sh	ot				
Si Atte	ica	2 Accident Investi	28e Place of In	jury - At home, t	farm, street	, factory, offi	ce bu	ilding, etc	. 2	8f. Location	(Street	and Numbe	r or Rur	al Route Num	nber, City
Division of Vital Records, tal or Attending Physician: The law requir rs after cleath al Director: After this certificate has been s led in by the funeral director, page 2 should t	Certification:	3 Suicide 6 Could determ	not be	wnhouse / R					- 1	or Town		e, Baltin	nore M	ΔD	
spi hou fill		4 Homicide								- 10		177	-		
he H in 24 he Fi	ca	(Check only Certifying Phy	sician: To the best of m iner:On the basis of example in the control of the basis of example in the basis of example in the control of the basis of example in the basis of e	-											
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	2	and manner stated.												
	2	29b. Signature and title of certifier						number						th, Day, Year)	,
O.C.M.E. April						ril 21, 20	06								
		30. Name and address of person w	ho completed cause of c	eath (Item 23a)											
l		Zabiullah Ali, M.D. A	ssistant Medical Ex	caminer 1	11 Penr	Street, E	Baltir	nore, M	1 D 2120	01					
S	tate	31. Date filed (Month, Day, Year)		r's Signature	1.	el a									
Regis		sanst d pr f	2006 Klasus	15.	Span										

State of Maryland / Department of Health and Mental Hygiene 2 0 0

)	15044
	3. Time of Death
	3:00 p M
ath	
rthp oun	lece (Stete or Foreign try) inia
1	0d. Inside City Limits
	1 ☐ Yes 2½ ☐ No
our	itry?

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Docestroon of Health and Martel Hundons.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

f Death		•	Reg. No).	00	10	0 7		
		2. Date of Do	eath Da	ıy	Year	3. Time			
		April				3:00	p ^M		
, or Location	n of Death		40	c. County	of Death				
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ar If Unders	er 24 Hrs. Min.	8. Date of Bi	av, Year,	321	Cou	plece (Stete ntry)	or roreig		
		Apr 25), 19	734	VILE	inia			
						10d. Inside	City Limit		
						1 □ Ye	s 2 <u>y</u> €N		
•			10g. C	itizen of V	What Cou	intry?			
)14			USA						
	Origin? (Spe	ecify Yes or N Rican, etc.)		14. Rac	e - Ameri	ican Indian,			
lo Specif		riioari, oto.,		Specify		, 610.			
10 Specii				Specify	whit	te			
16a. Decedent's Usual Occupation (Give kind of work done during most of working					usiness/lr	ndustry			
ier	ther's Name	(First, Middl		tel:		stry			
10. 1401	WIGHT S HALLING	, (i ii ai, iviiddi	, <i>171</i> 41100	Carrall	,		unk		
	nhas as Our	of Davida Num	har City	or Town	State 7	in Code)			
Archie Vivian Gary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Kelly McKenny/daughter 16 Guinevere Court Baltimore, 110 21237									
Court		imore,				Town, Stete			
olace)	!				,				
description of Co.	ality.								
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given in Pa	art I.	23e. Di	d tobacco	o use con	tnbute to	the cause	of death?		
- /		1 [Yes	2 No	3 Pr	obably 4	Unkno		
	DISEA	IF 24a. W		24b.	Were au	topsy findin	gs availa		
		pe	itopsy informed? s 2 2		death?	completion of 2 No	i Cause		
26. PI	lace of Deal	th (Check onl							
04		ome 5/2*Re		6 □Otl	her (Spec	cify)			
Injury at Work?		28d. Describ	_	_					
1 ☐ Yes 2	2 🗆 No								
fice		28f. Location City or	n (Street Town, Sta	and Num. ate)	ber or Ru	ural Route ∧	um <i>ber</i> ,		
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27. Manner of Death Matural Security									
cense numb	ber		29d. [Date sign	ed (Mont	h, Day, Yea	r)		
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my opinion	,	, death occur	n, death occurred at the time	o, death occurred at the time, date	o, death occurred at the time, date and place	, death occurred at the time, date and place, and due	, death occurred at the time, date and place, and due to the caus		

State Registrar 31. Date filed (Month, Day, Year) MAY 1 5 2006



			State of Maryland/Department of Health and No. 1 - State of Maryland/Department of Health and No. 2 - State	Mental Hyg	giene 006	15045							
	Physici		1. Decedent's Name (First, Middle, Last) Carokyn Lorraine Brown	2. Date of Dea	th 30,200 Gear	3. Time of Death							
	/Medic Examin Funeral		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Confirm Mc 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Prince Ger (Year) 9. Birth	orge's hplace (State or Foreign							
w.	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	02/09/1	961 Wa	10d. Inside City Limits							
2	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it a Medical Exactinal must be notified at	Funeral Director	md PG District Heights 10e. Street and Number 10f. Zip Code 20747	1	Og. Citizen of What Co	Yes 2 □ No untry?							
Вюшл	ours after dea ral', or Items Executive ma	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto III Yes, Give Year or Dates:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Bl								
mith Bra 21215-0036	e filed within 72 hours after at Hygiene other than "natural", or Ite vent, It e Mudical Exertical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	rkıng	16b. Kind of Business/	Industry							
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lyn Lor More, Ma	Pages 1 and 2 sent of Health are it if item 27 is		20a. Method of Disposition 1) Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify)	t Distri	20c. Location City or	md SU74 Town, State							
Ceron	permit. Pages Depertment of Importent: If I eny Injury or o		21. Signal Gre of Funeral Service Licensea 22. Name and Address of Facility Rubert G Mason 1661 Good Hope Rds										
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a footcome on the condition of the co		Approximate Interval Between Onset and Death								
8760,	cate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Compared to the says is sequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.		,								
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rds, P	iaw requires thet se been signed be should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lower Extrimites Rep Venous		ebacco use contribute to les 2 □ No 3 □ Pr								
I Reco	: The taw requ cete hes been page 2 shoul	Completed	Thrombosy	24a. Was a autop perfor 1 🗆 Yes	med? prior to death?	utopsy findings available completion of cause of 2 No							
Division of Vital Records, P.O. Box 68	the Hospitel or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires the theory after this certificate has been signed by the ettending physicien and pletely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	atlon: To Be	examiner? 1		ne) lence 6 ①Other (<i>Spe</i> low inju ry occurred	cify)							
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	the Hosp thin 24 hou the Fune mpletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one) 2 Signature and title of certifier 2 Occurred at the time, date and place (Check only one)	urred at the time, o	cause(s) and manner as date and place, and due 29d. Date signed (Mont	to the cause(s)							
	T with		Amer Ali Anjadi MD MDD59993		4,39,05	-							
_	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amirgi Ali Amjadi 8118 Good Luck Road 31. Date filed (Month, Day, Year) MAY 1 5 2006 Registrar's Signature	Lanham	, MD 2070	06							
×	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 5 2006 Registrar's Signature										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 28,2006 2145 P M JOSEPH WALTER BELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton, Maryland Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) April 9,1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 □ F 82 Elberon, VA Yrs Director 230-22-6548 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **e**how 27 is marked other then "natural", or iteme 23a or 28a-f show treumatic event, the Medical Examiner must be notified at ty⊈Yes 2 No Director District of Columbia Washington 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 20032 #80 Galveston Place SW #B United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after Yes 2 No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: à 3 Widowed 4 Divorced Year or Dates: 1945-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry se filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Supply Clerk Twe1th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F is marked of Unknown Unknown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is m eny Injury or other treum once. 5407 Woodland Blvd, Oxon Hill, MD 20745 Twanda Turner-Fisher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 9, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Quantico National 4 ☐ Donation 5 ☐ Other (Specify) 2006 Triangle, Virginia 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral Service Ligensee 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): CALDIOUAS CULAR Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): physicien a P.O. Box 68760 9 Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) g be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should ted Complet 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pendina 1 KNatural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation M completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death oncurred at the time, date and plane, and due to the nause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) State Registrar

			For State Registrar	State of Maryland		artment of He tificate of L			iene g. No. 20	06 15047
3	Physici	an	Decedent's Name (First, Middle, Last)	stood Bu	v.			2. Date of Deat Month MAY	Day	3. Time of Death Year 2006 9:05 Ft M
	/Medic		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of D		4c. County	
4.	- Addition	2	Saint Joseph Me	dical Cente	h.			son	E	Baltimore
4	Funeral Director		5. Social Security Number 220 - 52 - 4659 Usual Residence of Decedent	7. Age (In yrs. last 57	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	Hrs. 8. Date of Birth (Month, Day,	1948	9. Birthplace (State or Foreign Country)
	Maryland -f show	tor	10a. State 10b. County Md Baltimo	10c. City, To						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	i Director	10e. Street and Number 9105 Lamaze			10f. Zip Code	123		ng. Citizen of	What Country?
36	hours after death with the Maryland lural', or tteme 23a or 28a-f show al Examinational be notified at	by Funeral		. Was Decedent Ever in U.S. Armed Forces? Tyes 2 \(\subseteq \text{No} \) If Yes, Give Year or Dates:		_ L		? (Specify Yes or No- uerto Rican, etc.)	14. Rad	ce - American Indian, ck, White, etc.
21215-0036	72 B	Completed I	15. Decedent's Educa (Specify only highest grade of	tion 1	(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of	working	16b. Kind of B	lusiness/Industry
1212	filed within Hygiene. sther than "		Elementary/Secondary (0-12) 1 2 + 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		Inves	rigato	Name (First, Middle, M		imor Co.
Maryland	Mental Merked c	To Be	Rufus M. (Burke			Ella	- Marie	100	nes
	ロミトン		19a. Informant's Name/Relationship (Type	/. • 0			E3507 FEB	r Rural Route Number, 、火がルルル	52	
Baltimore,	of H of H fite	1 3	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	20b. Place ceme	e of Dispos etery, cren	sition (Name of natory or other place)	Date	20c. Location	City or Town, State Mills Md
Baltir	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licensee	Garri	22		s of Facility	Chatman-	Harris	Funeral Home
8	10 1 V G		23a. Part1. Enter the disease, or complica	tions that caused the death. E				on Rd Bal		Approximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	STOMACH CAN	CER					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent ASPIRATION		MONIA				
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):					
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9	ificate g phys as the	ledical	d							
O. Box	at the death certificate be executed by the attending physiclen and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown	ath 3	Ectopic pregnancy Other (specify)			1	ate of delivery onth Day Year
rds, P.	es tha	by	Part II. Other significant conditions contri	buting to death but not resultin	ig in the ur	nderlying cause give	n in Part I.	23e. Did tob	4.1	tribute to the cause of death?
	The law ate has b page 2 si	Completed						24a. Was ar autopsy perform	/	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	spital:		Other		Death (Check only one)	
of	ding Phys h. After this funeral di	tion: To	TE TOS ZA NO	1 Inpatient 2 LEH	Outpatien b. Time of Injury	28c. Injury Work	4 🔲 Nursir	28d. Describe ho		
É	i gige	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Numb State)	per or Rural Route Number,
	o the Hospital or ithin 24 hours effe the Funeral Dir impletely filled in	edical C	29a. Certifier (Check only one) 12 Intifying Physic 2 Inhedical Examine	ian: To be best of my knowled r: On the basis of examination and anner stated.	dge, death and/or inv	occurred at the time restigation, in my opi	e, date and pl inion, death o	lace, and due to the ca accurred at the time, da	use(s) and ma te and place,	anner as stated. and due to the cause(s)
= 1	To the H within 24 To the F c implete	Me	29b. Signature and title of continer	That -	_	29c. License	number	250	d. Date signer	d (Mohth, Day, Year)
,	4		· July				30149		11'	1.6
1	/ ,		30. Name and addless of person who com	orered cause of death (Item 23)	a) (Type, i	rint)	SCHALIN	ARYLAND S	1004	
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 1 5 2006	3 Registrar's Signature	100	A)	The state of the s		- ds. Jen. Sail "T	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		irtment of tificate o			Reg. I	-211116	15048
	Physici		1. Decedent's Name (First, Middle, Last)						ate of Death Ionth	Day Year	3. Time of Death O1:30 AM
	/Medic Examin	al er	Franklin A. 4a. Facility Name (If not institution, give str S. A. Hoserrac 5. Social Security Number 6. Sex		birthday)	B Ac		24 Hrs. 8, D	ate of Birth	2 7004 4c. County of Death	place (State or Foreign
**	Funeral Director		136-26-7607 Usual Residence of Decedent	^{1 2□F} 70	Yrs.	Months Day	rs Hours	Min. No	v · 6 , 1	935 Peni	nsylvania
	Aaryland F ehow	or	10a. State 10b. County	10c. City, T		wings	Mills				10d. Inside City Limits 1 ☐ Yes ② No
	r 28a-f	Director	MD Baltimo 10e. Street and Number	1.6		10f. Zip Code			10g.	Citizen of What Cou	ıntry?
	th with	al D	111 South Ritt	ers Lane			117			U.S.A	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show all night or other traumatic event, the Medical Exart at most be notified at once.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? ₩₩es 2 □ No If Yes, Give Year or Dates: Korea		Was Decedent of f Yes, specify C 1 ☐ Yes XIXN		gin? (Specify) , Puerto Ricar	fes or No- n, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
215-0036	nin 72 hou in "nature Medical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	dent's Usual Oct kind of work do DO NOT use ret	ne during most ired)	_	1		e County
2	giene /giene ier tha	Com	12		Chie	ef Cus					ducation
Maryland	uld be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Raymond Burchi				Emm	na Mac			
Man	2 sho and l		19a. Informant's Name/Relationship (Type							tyorTown,State,Z ∾c Mills	ip Code) s, MD 21117
	1 and Health tem 27		Joyce Burchill 20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of	1	Date		Location - City or 1	
по	Pages ent of nt: If It ry or o		XIXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			matory or other i		em. 5,	/16/05	Sykes	ville, MD
Baltimore,	permit. Departm Importation any Inju-		21. Signature of Fineral Service License	mm	1	1605 R	eister	stown	Rd.Ow	ings Mil	napel P.A. 1s,MD2111
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.				cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen		CANCER					
ı	Examiner	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons) uer	nce of):						
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.O. Box 68	ne death certific tha attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deat	eath 3[□Ectopic pregna □ Other (specify			7.5.77	23d. Date of deli Month	very Day Year
<u>α</u>	uires that the signed by Id be detacted	à	Part II. Other significant conditions cont	ributing to death but not resulti							the cause of death?
Recor	The law require ate has been si page 2 should b	Completed	Diabetes mellito				****		24a. Was an autopsy performer	d2 death?	itopsy findings available completion of cause of
tal	sicien: T certificate rector, pa	0	25. Was case referred to medical				26. Place		1 ☐ Yes 2 © leck only one)	NO 10163	2.02.110
Division of Vital Records,	ng Phys fter this neral dir	on: To B	examiner? 1 □ Yes 275 No Ho 27. Manner of Death 1 15 Natural 5 □ Pending		P/Outpatier 8b. Time o Injury	of 28c.	njury at Work?	28d.		e 6 □Other (Specinjury occurred	city)
Divisio	i Dife	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, st		1 Yes 2 l	28f. I	Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
)	Hospital 24 hours 2 Funerel stely filled	Medical Co	29a. Certifier 106 Certifying Phys (Check only 2 Medical Examin one)	icien: To the best of my knowle er: On the basis of examinatio and manner stated.	edge, deat n and/or in	th occurred at the	ne time, date an ny opinion, dea	nd place, and outh occurred a	due to the caus t the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	within 2 To the comple	Me	29b. Signature and tule of dertifier		·		cense number			. Date signed (Mont	
			> XLLS no			1	2ES- 80	8 Ø	M	Ay 12, 2	000
1	20		30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Type,	, Print)	0				
	<u>y</u>	ate	J. A. Yolto MI) 31. Date filed (Month, Day, Year)	24°\ W\$5~\	VEWED 18	iene Ave	· Donesto	noré, s	40 21	213	
	St Regist		MAY 1 5 200	R)	An	- 6° 0					

DHMH 17 Rev 1/2001

BUTCHILL, FRANKLIN A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:20am Albert E. Bolan May 7, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 7/24/1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1137M 2□ F 405-44-3793 73 Yrs. Director ΚŸ Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 √Yes 2 No Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11228 Ministrel Tune Drive 20876 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ZYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🖫 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯XNo Specify: Specify: ģ black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer IBM 12 5+ permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert E. Bolan Roena Whitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Bolan / Wife Minstrel Tune Drive Germantown MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvery Cemetery May 13, 2006 Louisville, KY peral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Ave, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neumonia **Examiner** Physiclan/Medical Examiner Pleural Effusion The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown Lung Mass þ sete has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Dah 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗆 Homicide

To the Hospital or Atter within 24 hours effer der To the Funeral Director completely filled in by th

State Registrar

Medical

31. Date filed (Month, Pay, Year)

29a, Certifier

29b. Signature and title of certifie

Robert Ryan Holmes 32. Raistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0062653

29d. Date signed (Month, Day, Year)

May, 7, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland		artment of H rtificate of I		d Mental H	211	06 15050
			Decedent's Name (First, Middle, Last))			304.77	2. Date of	Reg. No.	3. Time of Death
Н	Physici		. homes	Beasless				Month	- 0ª 21	Year 17:45PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of D	Death	4c. County o	of Death
		•	354 ELSWOY9	Str P/		Jonna	town	10	Har-f	ord
	Funeral		5. Social Security Number 6. Se		st birthday)	If Under 1 Fear Months Days	If Under 24 Hours	Hrs. 8. Date of I	Birth Day Year)	Birthplace (State or Foreign Country)
	Director		231 42 0401	⁹⁴ 2□ F 77	Yrs.	Miditals Bays	1,0013	Apr		
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits
	Aaryla f aho	ō		Harford	Jor					1 ☐ Yes \$45xNo
	the A	ect	10e. Street and Number	driord	OOL	10f. Zip Code			10g. Citizen of W	hat Country?
	with Ba or	Ö	354 Ellsworth P	lace		101. 2.0 0000	2108	35	rog. Galleon of the	USA
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow the Madical Examiter must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S		Was Decedent of Hi	spanic Origin	? (Specify Yes or	No- 14. Race	- American Indian,
9	or Ites	Für	1 ☐ Never Married 2 ☆ Married	Armed Forces? 1 GyYes 2 □ No If Yes, Give		f Yes, specify Cuba		uerto Rican, etc.)	Black	, White, etc.
21215-0036	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Dece	dent's Usual Occupa	ation during most of	workina	16b. Kind of Bus	siness/Industry
2	ithin ne.	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			
7	filed w Hygier other ti ent, ti	CO	11	0		Shipping				port Co.
Maryland	be fi	Be	17. Father's Name (First, Middle, Last) Manley Beasley					ry Alford	fle, Maiden Sumame	"
Ĕ	should Ind Mening Market	은	19a. Informant's Name/Relationship (T)	una Printl	10h Mailir	a Addross (Street :			nber, City or Town, S	State Zin Code
<u>M</u>	2 6 2 6		Frances Beasley						MD 21085	
ē,	t and Health tem 27 other tr		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of	- 1	Date		City or Town, State
Ω	Pages nent of I int: If its iry or o		1-☐Burial 2 ☐ Cremation 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	-	natory or other plac National		5/10/2006	Florence	0 80
Baltimore,	ortar injur		21. Signature of Funeral Section (Specify)		22	Name and Address	s of Facility		-	•
ä	permit. Departr Imports any inj	Y I	+ 10	Victor Doda	1	harles L. 501 E. Fo	Steve	ens Funer enue. Bal	al Home, timore MD	Inc. 21230
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the death.						Approximate Interval Between
Е	Physician ¹		Immediate Cause (Final disease or condition	Moto Static	Car	cinoma	of.	tolade	2	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		CLIMINA	-4	Viance		9 moreu
	Examiner		Sequentially list conditions,	0						
	p tis	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
	ecute and -trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nao of\:					
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Box	atter after	ciar	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Mont	
P. 0.	the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	Attending Physicien: The law requires that the death certific reasth. r death. ector: After this certificate has been signed by the attending pot the funeral director, page 2 should be detached for use as by the funeral director.	by P	Part II. Other significent conditions con	ntributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Die	d tobacco use contrib	oute to the cause of death?
Records,	w require been sig should b	ed b						_ 10	Yes 2 40 3	3 Probably 4 ☐Unknown
ပ္တ	aw re	Completed						24a. W		ere autopsy findings available
	The I	Eo						— au pe 1 Yes	rformed? de	ior to completion of cause of eath? ☐ Yes 2 ☐ No
ta	ian: rtifica stor, p	Be C	25. Was case referred to medical				26. Place of	Death (Check only		
<u>_</u>	nysic ais ce direc	10	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursir	ng Home 5 1	sidence 6 Other	(Specify)
0	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 GNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describ	e how injury occurred	d
Sio	Attendi er death. rector: A by the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				res 2□No			
Division of Vital	. 0	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office			(Street and Number own, State)	r or Rural Route Number,
ш	pital ours a eral [29a. Certifier 1 Certifying Phy	pinion: To the heat of my know	lodgo doeth	and at the time	o data and a	loop and dup to th	10 20 10 10 10 10 10 10 10 10 10 10 10 10 10	anna stated
	24 hos 24 hos Fun etely	Medicai	(Check only 2 Medice! Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	on and/or in	vestigation, in my op	pinion, death o	occurred at the tim	e, date and place, ar	nd due to the cause(s)
	To tha Hospital or within 24 hours after to the Funeral Direction (completely filled in	Me	29b. Signature and title of certifier	7 .	, 11	29c. License	number	-	29d. Date signed	(Month, Day, Year)
	1		> Thusfills	MUCHEM.	Me	DA	1209	793	5.5	06
	8		30. Name, and address of person who	ompleted cause of death (Item	23a) (Type,	Print)	100		00	
			Howlett Jac	4809, M.D.	6115	union	Ave	Havrel	De Grace	MD 21028
		42	31. Date filed (Month, Day, Year)	32. pegistrar's Signatu	ıre	•				
	Sta Registr		MAY 1 5 20	nc A	to d	W -				

State of Maryland / Department of Health and Mental Hygiene 2 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ''14**,** May 2006 8:45 A. LeRoy W. Black, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 15, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 ☑ M 2 ☐ F **Funeral** 212-09-2561 Maryland Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Mary land Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3673 Cragsmoor Road 21042 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∏ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify Specify: White Completed by 3 ₩ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. 3^{College (1-4or 5+)} Elementary/Secondary (0-12) Attorney Irvington Federal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event one. Be LeRoy W. Black, Sr. Estelle Zimmermann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LeRoy W. Black III /Son 3673 Cragsmoor Road Ellicott City, Maryland 21042 20a. Method of Disposition
1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Moreland Memorial Park 5/17/06 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton

21. Name and Adress of Facility

Leonard Linck. Inc.

22. Name and Adress of Facility

Leonard Linck. Inc.

23. Signature of Funeral Service Licensee Christina L. Hilton

23. Name and Adress of Facility

24. Licensee Christina L. Hilton

25. Name and Adress of Facility

26. Licensee Christina L. Hilton

27. Name and Adress of Facility

28. Licensee Christina L. Hilton

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24. Licensee Christina L. Hillon

24. Licensee Christina L. Hillon

25. Name and Adress of Facility

26. Licensee Christina L. Hillon

26. Licensee Christina L. Hillon

27. Name and Adress of Facility

28. Licensee Christina L. Hillon

28. Licensee Christina L. Hil 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHF PROS /Medical Due to (or as a consequence of) Examiner CAD Sequentially list conditions, Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 200 : After this certifica e funeral director, p 25. Was case referred to medical Be 26. Place of Death | Check only one examiner Cther: 4 Nursing Home 5 Residence 6 Ather (Specify) HOSPICE 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and tale of certifier 29d. Date signed (Month, Day, Year) May 14, 2006 D0051926 40 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES STREET Helen M Gardon MO TOWSON, MD Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11 Emily L. Barto May 2006 3:28 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 216-56-7800 50 Nov 16, Director 1955 Pennsýlvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at Baltimore County Maryland Towson 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 105 Kenilworth Park Drive 21204 United States Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Routzhaun's Department 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Store Advertising Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be finance and Mental File marked of Joseph Artley Nancy Dickie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 partment of Health a portant: If item 27 is y injury or other trait Mrs. Nancy Artley (Mother) 105 Kenilworth Park Drive, Towson Maryland, 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland Evans Funeral Chapel May 12,2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral&Cremation Ctr.P.A. 2325 York Road Timonium Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dhermonia **Physician** weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). Box 68760. ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) O detached Physi 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably as been si 1 ☐ Yes 2 ☐ No 4 □Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2ª No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)25205 MAY 12, 2006 und € pleted cause 1 ath (Item 23a) (Type, Print) 6601 N, CHARLES TREET LOWSON, MD ŧ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

3:28p.m

200

Barto, Emily

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** BANNET 9:15 AM WILLIF 2006 MAY /Medical 4c. County of De 4a. Facility Name (If not institution, give street, and number) Examiner Battimore Bon Secours 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** -5272 Months 102M 2□F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Nes 2 No Directo Maryland 10e. Street and Numb 10g. Citizen of What Country or iteme 23a or 281 Funeral Was Decedent Ever in U.S. Armed Forces? 1 yes 2 you If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. 90 NOT use retired) 16b., Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "na eny injury or other treumatic even" during most of working ondary (0-12) College (1-4or 5+) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name Willie Banner 19a. Informant's Name/Relationship (Type, Print) Southland 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner endom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ed by the ettending physicien and deteched for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 em 9 ongo IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No after death.

Director: After this certification of the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitei o within 24 hours aft To the Funeral Di 1 Cartifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier BD6900410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD JAIN, 31. Date filed (Month, Day, Year) MAY 1 32. Pagistrar's Signature State 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

			1 - For State Registrar	State of Ma	ai yiai iu	•	tificate			-	Reg. No.		10007
	Sale of the sale of	19	Decedent's Name (First, Middle, La	st)						2. Date of De	ath		3. Time of Death
- (Physicia		Henrietta Blak	ce						May Month	5 9	20 [°] 06	12:12PM
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, To	wn, or L	ocation of Dea	ith	4c. Cou	nty of Death	
			225 Admiral Far	ragut Ct	. Apt	204	Ar	nnar	oolis		Ann	e Aru	ındel
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. las		If Under 1	Year	If Under 24 Hr Hours Mir	s. 8. Date of Bir	th Voorl	9. Birthp	olace (State or Foreign
Ь	Director		212-34-4327	□M 2√F	7	O Yrs.	Months	Days	Hours Mir	s. 8. Date of Bir (Month, Da Nov 12	2 1935	Mai	ry1and
	D		Usual Residence of Decedent										
	rylar	<u> </u>	10a. State 10b. County			Town or Loc						1	10d. Inside City Limits
	the Marylar 28a-f show	cto	Maryland Anne A	runaer ————	AIIII	apol:	1.5						M∑Xyes 2 □ No
	th th or 28	Oire	10e. Street and Number				10f. Zip C				10g. Citizen		ntry?
	23a	ail	225 Admiral Far	ragut Ct.	. Apt	204	2	140	1		USA	<u> </u>	
	ems err	Inel	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Deceder Yes, specify	t of Hisp Cuban,	panic Origin? (Mexican, Pue	Specify Yes or No rto Rican, etc.))- 14. F	lace - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any righty or other traumatic event, the Medical Examinatry until by multipad at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	40		☐Yes X						lack
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15	in 72 n "ne	Completed	(Specify only highest gr	ide completed)		(Give I	kind of work OO NOT use	done dui retired)	ring most of w	orking	Mary1		•
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	Hyg Hyg other	e C	17. Father's Name (First, Middle, Last)	'			1	8. Mother's Na	ame (First, Middle	, Maiden Suп	ame)	
Maryland	d be ental ked c	To Be	Thomas Blake						Marv	Downs			
7	shound M mar	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (S	Street an		Rural Route Numb	er, City or Tox	vn, State, Zip	Code)
N	ith ar		Earlene Hardes	tv(Daught	er)	1203	Van	Bur	en St.	Annapo	olis,	Md. 2	21403
ē,	Hea tem othe		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name	of		Date	20c. Locatio		
Baltimore,	ages ant of it: If I		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Mos	es Ce	atory or other	r piace) r y	5-1	1-06	Drury	, Md.	
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68760	tificate be executed g physicien and as the burial-transit	Aedicai Examiner	(d									
68	tificate og phys as the	edi											
Box		N/M	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome			ST -+ :				23d.	Date of delive	эгу
m	death e atte d for	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☑ No.	1□Live birth 4□Pregnant at			Ectopic preg Other (spec					Month	Day Year
0	by the	hys	9 ☐ Unknown	9□ Unknown									
9	Physician: The law requires that the death cer this certificate has been signed by the attendir tal director, page 2 should be detached for use	by P	Pan ff. Other significant conditions	contributing to death b	ut not resulti	ng in the un	derlying cau	se given	in Part I.	23e. Did t	obacco use c	ontribute to th	he cause of death?
ğ	quire n sig uld b		Hypertron's	; 810	out	net	1 Hou	لع	77	X	Yes 2□No	3 🗆 Prob	ably 4 Unknown
Records,	s been si should!	Completed	Acadent L	Joe L-P	rdo_	oin				24a. Was		b. Were auto	psy findings available
Re	he ta e ha age 2	mc		1							rmed?	death?	mpletion of cause of
Vital	ifficat	a)	25. Was case referred to medicaf					2	26 Place of Da	1 ☐ Yes eath (Check only o	20 No	1 🗆 Yes	30 No
>	s cert	To B	examiner? 1 Yes 2 SNo	Hospital:	nt 2 EF	3/Outnatient	3 □ DOA	Other:			dence 6 0	Other (Specif	·
of	Phy er this		27. Manner of Death	28a. Date of fnju (Month, Da		8b. Time of		Injury a Work?		28d. Describe			7/
lon	th.: Afte	tlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury	м		s 2 No				
Division	Attending r death. ector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could not b	289. Place of inf	ury - At hom	e, farm, stre	eet, factory, o	office		28f. Location (Street and Nu	mber or Rura	al Route Number,
Ö	a afte	Certification:	4 Homicide	building, et	c. (Specity)					City or To	wn, State)		
	hours hours unere	ai (29a. Certifier 1 Certifying Pl	ysicien: To the best	of my knowle	edge, death	occurred at	the time,	, date and place	e, and due to the	cause(s) and	manner as s	tated.
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and manner sta	ated.	ii aiiuvoi iiiv	1			Julieu at the time,			
	To To	2	29b. Signature and title of certified	11. HH	1-		79c. L	icense r	number	>	29d. Date sig	ned (Month,	Day, Year)
	á		rem !	2 con	1		10	OO	146	3	57	10/1	36
	2		30. Name and address of person who	completed gause of d	eath (ftem 2	Sa) (Type,	rint)	. 1	1	100	K		0011601
			CKKO/N	1 m	tron	1/2	Dans.	\	redu	of the	of the	no. N	1917
27	Sta		31. Date filed (Month, Day, Year) MAY 1 5 2	OOC 32 Tagistra	Signatur		of -			,	3		-
	Registr	ar	MULT T 9 7	UUU DOOR	20 /65	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 State Registrar Amend Item #8&18 Per FH C855 Ceptificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:10 A M Cascio 2006 trances 10 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Timonium Baltimore Stella Maris If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. May 27, 2006 Maryland 7. Age (In yrs. last birthday). 5. Social Security Number **Funeral** 1□M 2X0F Yrs. 215-09-6123 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 'natural', or iteme 23a or 28a-1 ehow 1 Yes 2 No Funeral Director Baltimore MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 USA 3715 Oakfalls Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home . Pages 1 and 2 should be filed w trent of Health and Mental Hygie tant: if item 27 ie marked other ti jury or other traumatic event, to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) (unk) Salvatore Ciotta Josephine Caruso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3715 Oakfalls Way, Baltimore, MD. Christine Cascio(daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Doyation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or once. Dulaney Valley Mem Gard. 05/15/06 Timonium, Maryland 21. Sign we of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lung Cancer 6 months /Medical Due to (or as a consequence of) Examiner PULMONARY EMBOLUS 3 months S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of) Examiner ete hes been signed by the ettending physicien end page 2 should be deteched for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2€ No 24a. Was an performe this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4x Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 28 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours e To the Funeral L

Baltimore, Maryland 21215-0036

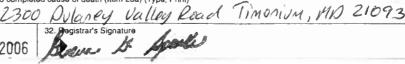
State Registrar

31. Date filed (Month, Day, Year) MAY 1 5 2006

sonnel Colon MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

May 10, 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 | 5056

		1- For State Registrar	C	Certificate	of Dea	th		Reg. No.	
Physicia	n/	Decedent's Name (First, Middle,Last)					Date of De Month	eath Dav Ye	3. Time of Death
Medical Examin		Billy Wa 4a. Facility Name (if not institution, give si	ayne Corb	<u>itt</u>	4b City	Town, or Location of	May 9, 20	4c. County	1843 nrs
		Franklin Square Hospital	Jeet and namber,		Rose		Deali		ore County
Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday		der 1 Year If Under	24Hrs. 8. Date of B		Y) 9. Birthplace (State or
Director		215-92-8464 IXM	1 2 F 39		Yrs. Month	ths Days Hours	Min. Feb 2	4, 1967	Foreign Country) Maryland
_		Usual Residence of Decedent					11165 2	7, 1707	
w any		10a. State 10b. County		City, Town or L	ocation				10d. Inside City Limits
Maryland 28a-f show d at once.	ğ	Florida Volusia	1	<u>r</u>	Deland		·		1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	6				10f. Zip			10g. Citizen of W	,
ith the	瞐	740 North Woodland 11. Marital Status	Blvd. Apt 12. Was Decedent Ever in	721	Was Dans	32720			l States
ath w items	Funeral	1 Never Married 2 X Married	Armed Forces?			ient of Hispanic Origir cify Cuban, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)		e - American Indian, Black, ite, etc.
ter de		3 Widowed 4 Divorced If		0 1	Yes :	2 X No specify:		Specify:	White
ours af atural	a þ	15. Decedent's Education (Specify only	r Dates: highest grade completed		edent's Usual	Occupation (Give kir			susiness/Industry
6 72 hc 21 Ex	et	Elementary/Secondary (0-12)	College (1-4 or 5+)	durir	ig most of wo	orking life. DO NOT u	se retired)		
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Completed	9th		В	Builder				struction
21215-0036 uld be filed within 7 Mental Hygiene revent, the Medica		17. Father's Name (First, Middle, Last) Billy Wayne	Corbitt, S	Cw			Name (First, Middle,		
212 ald be Menta mark	- Be	Billy Wayne 19a. Informant's Name/Relationship (Type			ailing Addres		ion Juar per or Rural Route Nu		Gallier
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", e injury or other traumatic event, the Medical Examiner.	-1	Marion Corbitt/moth		- 1					Deland, FL32720
e, N l and Healtl item		20a. Method of Disposition	20	0b. Place of Dis	sposition (Na	ame of cemetery,	Date		- City or Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 Burial 2 X Cremation 3 Donation 5 Other Specify:		•	or other place undel (5/13/2006	Odent	on, Maryland
aftir mit. F Sartme portal	1	21 8 Ignature of Funeral Se vice Licenses		SSL ALG	22. Name and	Address of Facility	al Home &	- Juent	.011, Marytanu
ii ii get	· I	Juanta Q Hom	93		Dona10	ison Funer Annapolis	al Home & Road Ode	Crematon. Ma	ory, P.A. aryland_21113
Physician	П	23a. art I. Enter the disease, or complica failure. List only one cause on each	ations that caused the de	ath. Do not en	ter the mode	of dying, such as car	diac or respiratory ar	rrest, shock, or he	eart Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Gu	unshot wound of ch						Death
		or condition resulting in death)	e to (or as a consequenc	e of):					
	ē		e to (or as a consequenc	ce of):					
	.⊑∣	cause. Enter Underlying Cause (Disease or injury that initiated c							
ted /	Exa	events resulting in death) Last Due	ie to (or as a consequenc	æ of):					
		d. UNPENDED A	AMENDED						
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∞ = ∞ s l	an/I		1 Live birth	2	Fetal death	3 Ectopic p	pregnancy	Month	· ·
Box 68 e death certi	Physicia	1 Vos 3 No 9 Hakaaya	Pregnant at time of 9 Unknown	of death 5	Other (Spe	acify)			
~ # & € 1	튑	Part II. Other significant conditions co		not resulting in	the underlyin	o cause given in Part	23e. Did	tobacco use contr	ribute to the cause of death?
ires that the signed by I be detacl	ক্র	ū			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9			Probably 4 Unknown
ords, w require us been si should b	Completed						24a. Was	s an 24b	Were autopsy findings available
COF ; law r ; has t e 2 sh	g						auto	ppsy	prior to completion of cause of death?
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sled in by the funeral director, page 2 should led in by the funeral director, page 2 should		25. Was case referred to medical				CO Diese of Dogth //	1 ✓ Yes		Yes 2 No
fital sician sician is cert lirecto	<u>سّ</u>	examiner? Hos	pital: 1 Inpatient 2	✓ ER/Outpat		26.Place of Death (C		Residence 6	Other:
n of Vit ling Physic After this of	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time		28c. Injury at Work?		how injury occur	
ending ath or: A	[흲	1 Natural 5 Pending	FOUND: Day, Year)	FOUND:		1 Yes 2 🗸 N	Subject wa		
/iSi	lica	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - A	1800 hrs At home, farm,		y, office building, etc.			per or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: etely filled in by the	Certification:	4 Homicide determined	(Specify) Single F	amily			3717 Bay D	State) Orive, Middle	River, MD
Hosp 24 hc Fund etely f		29a. Certifier (Check only 1 Certifying Physician:	: To the best of my know						
Division To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical		n the basis of examination	n and/or inves	tigation, in m	y opinion, death occu	urred at the time, date		
	Ž	29b. Signature and title of certifier			29	c. License number		29d. Date sign	ned (Month, Day, Year)
		Merz				O.C.M.E.		May 10, 20	006
3	Ī	30. Name and address of person who com					4004		
ا د	- 1	Ana Rubio MD. Assistant I	Medical Examiner	111 Pen	n Street, F	Baltimore, MD 2	1201		i
	_	31. Date filed (Month, Day, Year)	32. Registrar's Sign						

ORIGINAL

	-	For State Registrar	State of Maryla			nt of H te of L			Reg. No.	2006	15057
Physicia	n	Decedent's Name (First, Middle, Last, LIADDV		C	LIANT	VED		2. Date of De Month MAY	Day	2006	3. Time of Death 4:05 P M
/Medic Examin	al	HARRY 4a. Facility Name (If not institution, give	street and number)		HANT 4b. City		Location of Death			County of Death	4:05 P
LXairiii	51 %-	MANOR CARE - RUXT	ON			MSON				ALTIMORE	
Funeral Director		222 21 0000 .	7. Age (In yrs	s. last birthday) Yrs.		Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09/17/	1916	9. Birth	place (State or Foreigntry)
Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTI		OWINGS		LS					10d. Inside City Limits 1 ☐ Yes 2 🖔 No
a or 28s	i Direc	10e. Street and Number 4730 ATRIUM COURT	#278		10f. Zi	p Code 2111	7		-	en of What Cou	ntry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleath and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "naturel", or Iteme 23a or 28a-f ehow or other traumatic event, the Madical Examinan must be a willied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Dece If Yes, spe 1 Yes		spanic Origin? (So n, Mexican, Puerto Specify:	pecify Yes or No pecify Yes or No pecify Yes		4. Race - Ameri Black, White, Specify: Wh	
ed within 72 hours afl giene. erthen "naturel", or the Madical Exem.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			kind of w DO NOT	ual Occupa ork done d use retired	ation furing most of won)	king		d of Business/Ir	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Man	Be Co	17. Father's Name (First, Middle, Last)	1	SALE	SMAN		18. Mother's Nam	ne (First, Middle	, Maiden S		
d 2 should be file th and Mental Hy 77 Is marked oth traumatic event	To	ABRAHAM 19a. Informant's Name/Relationship (T)	rne Print)	CHANTK		s (Street a	LILLIE and Number or Ru	ral Route Numb	BRES		p Code)
1 and 2 st Health and em 27 ls r		ALAN CHANTKER / S			,	,	LACE - B		E, MC	21217	
permit. Pages 1 ar Department of Hea Important: If Item eny injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State AN	Place of Dispo Comptent Con SHE EMU HAIM CO	NAH or	ame of Other place AITZ	05/1	2/2006		IMORE,	
permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens		22	2. Name a					BROS.,	INC. MD 21208
Physician /Medical		23a. Parn , Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)								30515	Approximate Interval Between Onset and Death
ficate be executed physicien and physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	equence of):	ROK	(E					weeks
death certif	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. II yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tat death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)			2	3d. Date of deliv	ery Day Year
uires that t signed by Id be detai	ρ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying	cause give	en in Part I.		tobacco us		the cause of death?
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ਦੂ ਦੁਛ	lon: To	27. Manner of Death 1 Satural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work	4 Nursing H	ome 5 ☐ Res 28d. Describe		Other (Speci	<i>Τ</i> Υ)
eat or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str city)					(Street and wn, State)		al Route Number,
To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one) 2 Medical Exam	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurre vestigatio	d at the time	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as splace, and due to	stated. to the cause(s)
To th within To th comp	Me	29b. Signature and the of certifier	ladi mo			9c. License 0-00		9		signed (Month,	
5		30. Name and address of person who o		em 23a) (Type,	Print)	SLE	R Dr	· Vou	1501	V MI	6 2120.
Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sig		wells!						

		1 - For State Registrar	State of Marylar		artment of F			000	CHEOR
		Decedent's Name (First, Middle, Last)		initale of	Dealii	2. Date of Dea		3. Time of Death
	Physician Medical/	Dorothy R. Dougl	as				Month Mav	Day Yea	3.4
	Examiner	4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of D	
		Genesis HealthC				ston		Tal	
	uneral irector	5. Social Security Number 6. Se 220-09-4381	x 7. Age (In yrs. ☐ M 2☐ F 91	. <i>iast birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 12/26	h y, Year) /101/ Mar	Birthplace (State or Foreign Country) ryland
0		Usual Residence of Decedent				<u> </u>	12/20	/1)14 Ma	Lyland
arylar	show	MD 10b. County Talbot	10c. Ci	ity, Town or Lo		ston			10d. Inside City Limits
£ May	28a-f	10e. Street and Number				5011			1 Tes 2 No
with	3a or	610 Dutchmans Land	2		10f. Zip Code 216	01		10g. Citizen of What U.S.A.	Country?
death	rms 2	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - A	merican Indian,
aftar	or he and	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 🗹 No	an, Mexican, Puerto Specify:	o Rican, etc.)		hite, etc.
1as 21215-0036 d within 72 hours atter death with the Maryland gisna.	ier than "natural", or tems 23a or 28a-f si it, the Madical Examinar must be notified Completed by Funeral Director	3 Widowed 4 □ Divorced	Year or Dates:					Specify:	White
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aryland should be file and Mental Hy	ls markac aumatic					Mary Ka	zak		
Mar Mar Massh Mass	7 Is rr traum	19a. Informant's Name/Relationship (T) Earnest Rychwalsk:	•	190520 2.3				r, City or Town, State	e, Zip Code)
Norothy Itimore, M ii. Pages 1 and 2 rument of Health i	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at since. To Be Completed by Funeral Director	20a. Method of Disposition	20b. F	Place of Dispo	Elm Rd.		e, MD 2	1227 20c. Location - City	or Town State
Oro mor Pages	y or o	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	tomoval mom otato		natory or other place.			Elkridge,	
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		23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the deet ne cause on each, line.	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	sician ·	Immediate Cause (Final disease or condition	mon	11/101	7	0			Onset and Death
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X 3	physicisn and street transit the burial-transit edical Examiner	Cause (Disease or injury that initiated events	GAMUAL	17-2	arken	orchero	mi		Plan
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P.O.	ached ached	1 Yes 2 No 9 Unknown	9 Unknown	Jean 5	Other (specify)				
S, P	signed by the attending d be detached for use as d by Physician/Me	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ords	should b						1 □ Y	es 2⊡No 3□	Probably 4 Unknown
ecc law n	5 0 D						24a. Was a autops	an 24b. Were	autopsy findings available completion of cause of
E P	page Com						perfor	med?// death	es 2 No
Vita	ector Be	25. Was case referred to medical examiner?	lospital:		04.	26. Place of Deat	h (Check only or	18)	
Of Phys	F g	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of		4 Nursing Ho		ence 6 Other (S _f	necify)
ion Iding	e funeral	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 □	(?`` (es 2 □ No	Log. Doscribo III	ow injury occurred	
Division of Vital Records, to Attending Physician: The law requires taller death.	al Director: After led in by the funeral	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifi	ome, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Number or	Rural Route Number,
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Division of Vital Records, P.O To the Hospital or Attending Physician: The law requires that the within 24 hours after death.	To the Funeral Director: completely filled in by the Medical Certifical	Check only 2 Medical Examil	sician: To the best of my kno ner: On the basis of examina	wledge, death tion and/or inv	occurred at the time	e, date and place, pinion, death occur	and due to the c	ause(s) and manner ate and place, and d	as stated.
To the within 2	Med tha	one) 29b. Signature and title of certifier	and manner stated.		29c. License			9d. Date signed (Mg	
	⊢ ŏ	· as	MI MI	⁾	1)2	F7.10		5/10/1	26
•	2		mpleted cause of death (Item	1 23a) (Type.	Print)	, ,	1	11/0	<i>U</i>
)		2 MD 508.	IDLE	NILD AV	ENUE	LAST	ON MA	21601
	State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	5			,	

State of Maryland / Department of Health and Mental Hygiene? 🛭 🖯 🖯

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006 11:49 Am **Physician** Drake Kenneth C. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Manchester 3307 Kensington Square If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Ochlorth, Pay, Year) 15 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days England Months Hours 3€ M 2 F 215-09-8503 90 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show sust be notified at Manchester Carroll 1 Yes 2 No Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21102 U.S.A. 3307 Kensington Square Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amped Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Race - American Indian, Items ; 11. Marital Status the Medical Examiners Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Ma. yland 21215-0036 ٥ 1 ☐ Yes Ž ☐ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ' Lry or other traumatic event, the Ma College (1-4or 5+) Elementary/Secondary (0-12) Senior Mgmt. Ananlyst US Govt. U.S. Govt. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henrietta Catton Herbert Drake ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21102 3307 Kensington Square Manchester, Md. Muriel Drake/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cemetery, crematory or other place)
Garrison Forest Vet. Cem. 17,2006 1 Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Md. permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fy eral ervice Licens Name and Address of Facility Eckhardt Funeral Chapel 27102 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or pack line. Immediate Cause (Final Pars Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fulsease or injury that initiated events Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical been signed by the attending phys should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 donknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 ☐ Yes 25 No 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) on he sty Rd Manchester 1501 JUMD 2973M 1. Hen Herbert 31. Date filed (Month, Day, Year) State MAY 1 5 2006

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State o	f Marylan		artment or rtificate			nd M	•	giene	006	15060
			1. Decedent's Name (First	, Middle, La				2				2. Date of De Month	eath Day	Yeer	3. Time of Death
	Physicia /Medic		Georg	e	De	Zei	104					MAY	111	2006	2057M
	Examin		4a Facility Name (If not in	stitution, giv	e street and nur	mber)		4b. City, To	own, or	Location of	Death		4c. C	ounty of Death	
			BAlto W.	ASH	med	Ct	· V .		22	13		MIR		AA	
	Funeral		5. Social Security Number	6. S	ex XM 2□F	7. Age (In yrs.	•	If Under 1	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	place (State or Foreign htry)
	Director		578-03-5040		2UM 2UT	86	Yrs.					Oct 1,	1919		Colorado
	and *		Usual Residence of Deceded	Sent County		10c. Cit	y, Town or Lo	cation							0d. Inside City Limits
	Aaryli r •ho	5		ĺ.	1 1										1 ☐ Yes 2 🛣 No
	the 1	Director	Maryland Ar	ne Ar	unaeı			Jessu 10f. Zip C		-			10a. Citize	n of What Cour	ntrv?
	ous after death with the Maryland rat', or iteme 23s or 28s-f show Examiner marst be motified at		2015 Citrus	Arron	110				079	<i>I</i> .			_	ited St	
	leath The 2%	Funeral	11. Marital Status	Aven	12. Was Dece	edent Ever in U	.S. 13.				in? (Spe	cify Yes or No Rican, etc.)		Race - Americ	can Indian,
10		F	1 ☐ Never Married 2	☐ Married	Armed Fo	rces?					Puerto I	Rican, etc.)		Black, White,	etc.
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21215-0036	72 hours after "natural", or ite	Completed	15. Do	ecedent's Ed	ducation ade completed)		16a. Dece	dent's Usual (Occupa done d	ition	of workir	na	16b. Kind	of Business/In	
2 2	within 7 ene. than "r	p de	Elementary/Secondary		College (1	1-4or 5+)	life.	DO NOT use	retired,)	or working	<i>'</i> 9			
	od wi	Son			4y	r		Accou	nta					countin	g
Z E	d oth	Be	17. Father's Name (First,)	Middle, Last,)					18. Mother	's Name	(First, Middle	, Maiden St	ımame)	
SGC De	12 should be filed within h and Mental Hygiene. 7 le marked other than " traumatic event, the Mes	은	Hubert	Cleve		DeZerne					ith	Pear		aymond	
ar S	2 sh and and le m		19a. Informant's Name/Re											own, State, Zip	
	and ealth m 27		Wilbur R. De		/Brothe							Ct, #2			,VA 20109
2 8	Jes 1 of H if Ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cren		Removal from	SIZIU		sition (Name matory or other			_	ate	20c. Loca	tion - City or To	own, State
(h E	Pages ment of ant: If It		4 □Donation 5 □ C	ther (Specif	(y)	Wes		del Cr							aryland
GCO F Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Itam 27 le marked other than "naturany Injury or other traumatic event, the Madical Once.		21. Signature of Funeral S	0	thoma	6	<u>5</u>	2. Name and on alds Onalds 411 An	Addres on nap	s of Facility Funer olis	al H Road	ome & Oden	Cremar ton, l	tory, P Marylan	.A. d 21113
			23a. Part1. Enter the dise	ase, or com	plications that o	aused the deat	h. Do not en	er the mode o	of dying	, such as c	ardiac o	r respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		A		56/8	rotic	. /	HEA	rt	DIS	CA5	e	Onset and Death
	/Medical		resulting in death)		Due to	(or as a conseq									
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_	D =	ner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	te J	Due to	(or as a conseq	иепсе от).								
V	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c										
760,	ite be exi		resulting in death) cast		Due to	(or as a conseq	uence of):								
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o.	the a	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4⊟Pregr 9⊟Unkn	nant at time of d own	eath 5	Other (spec	:rfy)						
ď.	hat the deby	P.	Part II. Other significant of	conditions of	contributing to d	eath but not res	ulting in the u	nderlying cau	isa aiva	n in Part I		23a Did	tobacco use	contribute to t	ne cause of death?
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours effer death. To the Funeral Director: After this certificate hes been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	ed by	Tarrii. Guidi digiii.		Joint During to a	0411041104104	uning ar mo u						Yes 2		pably 4 Munknown
eco	e law re hes be je 2 sho	Completed	¹									24a. Was	psy	prior to co	psy findings available impletion of cause of
<u>ac</u>	The ete h) our										1 Yes	ormed?	death?	2 No
ita	iician: Thi certificete rector, pag	Be (25. Was case referred to	medical							of Death	(Check only	one)		
~	Physic this ce al dire	To	12 Yes 2 No				S R/Outpatie			4 🗆 1401	sing Hor	ne 5 Res	idence 6[Other (Specif	y)
0	ding P. J. After ti funera	ü	27. Manner of Death 1 Natural 5	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	f 28c	. Injury Work	at ?	2	28d. Describe	how injury o	occurred	
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Divis	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not b determined	289. Place	of Injury - At hing, etc. (Specif	ome, farm, st y)	reet, factory, o	office		2		Street and I wn, State)	Number or Rura	ul Route Number,
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	1 24 to Fu	Medical	(Check only 2 N one)	ledical Exar	miner: On the b and man	asis of examina ner stated.	ition and/or in	vestigation, in	n my op	inion, deat	h occurre	ed at the time,	date and p	ace, and due to	the cause(s)
_	To th withir To th	ž	29b. Signature and title of	certifier	~	DE	oute			number				signed (Month,	
			1/Alil	lui	8 XX	nice	De	レ) (0605	4		5	112/	6
	149		30. Name and address of	person who	7			Print) 69	5	- 4	3	las - M	2	1035	
	Sta	ite	31. Date filed (Month, Day	v, Year)						UV	ne	TICH		,	
	Registr		MAY		06	Registrar's Signa	y A	arte							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 5 Year **Physician** Loretta Mary Dwyer 10:32 a M 8 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince Georges Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) 8/16/1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🐼 F Months Days Hours Min 579-26-1719 89 Washington, DC Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits r Itame 23a or 28a-f ahow ther crust be notified at Maryland Prince Georges Laurel 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7411 Berryleaf Drive 20707 United States America Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 Ia marked other than "natural", or Itam any Injury or other traumatic avent, the Mudical Exertment 2002. Black, White, etc. 1 ☐ Yes 2x No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: þ 3 NWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Assistant Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John E. Boswell Josephine Duetesch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6715 Park Hall Dr. Laurel, MD 20707 Lois L. Schulze/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/2006 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Experal Service Licensee 22. Name and Address of Facility Fleck Funeral Home Van 7601 Sandy Spring Road Laurel, Maryland 20707 Approximate Interval Between Onset and Death ACUTE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULAR ACCIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine and i-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760, Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 □ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Diractor: d in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/9/2006 D24997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8317 Cherry Lane Laurel 20707 Luis A Casas 31. Date filed (Month, Day, Year) Projetrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 **Physician** 12, 12:00 P M J. Falter Mav Mary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Glen Arm Glen Meadows 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-03-1912 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M XXF Sicily 212-01-8380 93 Yrs. Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland al Hygiene.
I other than "natural", or iteme 23a or 28e-1 ehow vent, the Modical Examination at the modified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Glen Arm Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11630 Glen Arm Road 21057 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2XXNo Specify: þ XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0wn Home Housewife Years 12 permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cimino Marion Grimaldi Antonette ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Falter, III (Son) 10515 Virginia Avenue, Cockeysville, Maryland, 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 05-16-2006 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road RUCK TOWSON FUNERAL HOME, INC. Towson, Md. 21204 (R.G.Ruth) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final disease or condition resulting in death) Muocerdial inforction **Physician** 30 minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending for use as IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cete hes pege 2 s this certificete Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending To the mospine within 24 hours effer death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Doctor. D-17992. 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Goucher Blad Towson md21286 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician FRANKOVICH MAY MI CHAEL 10 2006 7:16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. Cilv. Town, or Location of Death Examiner JOSEPH RICHEY HOSPICE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sax 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Days Months Hours 219-74-6744 36 Yrs. 12/30/1969 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-1 show 1 ☐ Yes 2 ☑ No MD BALTIMORE Director OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 59 LOWER GATE COURT U.S.A. 14. Race - American Indian, Black, White, etc. 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married WHITE 1 Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene TITLE SETTLEMENT OFFICER REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finand Mental H PAUL FRANKOVICH 2 JANICE MEDIC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health itsm 27 JANICE SKLAR / MOTHER 5034 DURHAM ROAD WEST - COLUMBIA, MD 21044 At Pages 1 a. Jepstriment of Health Important: if its any njury of any 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition HILLTOP SERVICE CORP. 05/11/2006 TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature June Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 🗋 Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 WUnknown 24b: Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 1 Yes 2 25. Was case referred 26. Place of Death (Check only one) examiner' Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 In ther (Specify 1 🗌 Yes 2 ER/Outpatient 3 DOA

Division of Vital Records, P.O. Box 68760 Hospitai or Attending within 24 hours a To the Funarei C

28d. Describe how injury occurred

27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

State Registrar 1 Natural

2 Accident

4 - Homicide

3 T Suicide

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifig

29d. Date signed (Month Day, Year)

		-		partment of Health and Mertificate of Death		ene 1. No. 2 0 0 6	15064
ı	Physicia		1. Decedent's Name (First, Middle, Last) Lloyd M. Gardner, Sr.		2. Date of Death Month 5/11/06	Day Year	3. Time of Death 6:00artf
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 535 Matthews Avenue	4b. City, Town, or Location of Death Brooklyn Par	k	4c. County of Deat Anne Aru	undel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 76 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 1/8/193((par) 9. Birt	thplace (State or Foreign ountry) MD
	Maryland -1 show	tor	Usual Residence of Decedent 10a. State	Location klyn Park			10d. Inside City Limits 1 ☐ Yes 2 🖺 No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 535 Matthews Avenue	10f. Zip Code 21225	100	g. Citizen of What Co USA	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show ampiritury or other traumatic avant, the Mudical Examinar must be notified at ancie.	by Funera	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No Army If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
0-0171	within 72 hours after ene. then "neturel", or ite he Mudical Examina	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	tedent's Usual Occupation we kind of work done during most of work DO NOT use retired) Longshoreman	ing 16	Sh. Kind of Business.	Ipping
and z	td be filed v ental Hygie ked other t Ic avant, th	To Be Co	17. Father's Name (First, Middle, Last) Charles Gardner	18. Mother's Nam	e (First, Middle, Ma ed Walker	aiden Sumame)	
Mary	and 2 shoul alth and M 27 la marl ar traumatl		19a. Informant's Name/Relationship (Type, Print) Lloyd M. Gardner, Jr. / Son 19b. Ma 53!	iling Address (Street and Number or Rut 5 Matthews Avenue,	Baltimore	e MD 21225	<u></u>
ballillore,	Pages 1 ament of He ant: If itam ury or othe		1 2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ill Cem., May 15,	2006 Ba	oc. Location · City or altimore N	Maryland
Dail	Departit Departit Import any inj	(22. Name and Address of Facility Charles L. Stevens 1501 E. Fort Avenue			
ŧ	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not on shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	enter the mode of dying, such as parolac	_	wer	Approximate Interval Between Onset and Death
3/00,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
O. BOX 68	the death certificat y the attending phy ched for use as the	by Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	vlivery Day Year
ds, r	quires that the de n signed by the a uld be detached f	d by Pt	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	V	o the cause of death?
i Hecords,	Attanding Physician: The law requires that the rideath. sctor: After this certificate has been signed by th by the funeral director, page 2 should be detached.	Completed			24a. Was an autopsy perform 1 Tyes 2	prior to death?	utopsy findings available completion of cause of s 2 \sum No
or vital	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo 27. Manner of Death 28a. Date of Injury 28b. Tim	tient 3 DOA Cther: 4 Nursing H	th <i>Check only ne</i> ome 50 Resider 28d. Describe hov	nce 6 Other (Spe	ecify)
DIVISION OF	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification:	Accident Suicide Could not be determined Suicide y Work? M 1 ☐ Yes 2 ☐ No		eet and Number or F	iural Route Number,	
á	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the			eath occurred at the time, date and place	, and due to the car	use(s) and manner a	is stated.
	To the Ho within 24 h To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier	29c. License number		ole and place, and du	
)	107		30. Name and address of person who completed cause of death (Item 23a). Ty	pe, Print) 3001.	5, 11-	nove	r Sheet
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	half	m'0-	x M	D 2/225
	Regist	uai	MAY 1 5 2006 Klesus &	Marie			

Christopher Scott Goins

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygien

		1- For State Registrar		Ce	rtificate of	Death	Mental Hy		Reg No. 2	006	150
Physic Medical Exam							12	Date of Dea Month	Day Year		ime of Death
		4a. Facility Name (if not institut	ion, give street and number	er)		4b. City, Town, or Lo	ocation of Death	May 9, 20	006	_ 1	344 hrs
		St. Agnes Hospital			1	Baltimore	Jodnor of Dead		4c. County of No.		
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. I	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Bi	rth(MM/DD/YYYY)	9. Birthplac	ce (State or
Director		212 02 9910	1XM 2 F	34	l Yrs	Months Days	Hours Min.	12/20/		Foreign	Maryland
any		Usual Residence of Decedent 10a. State 10b. County	,	Idoa Chu	, Town or Locati						
*	L	MD Ball	timore		odlawn	on					Inside City Limits
Maryland 28a-f show 1 at once.	Director	10e. Street and Number				10f, Zip Code			0- 0:4:	1 _	Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once		5316 Dogwood	Rđ.			21207			0g. Citizen of Wha	it Country?	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiens the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at ones.	Funeral	11. Marital Status	12. Was Deceder			Decedent of Hispa	nic Origin? (Spec	ify Yes or No	USA 14. Race -	American In	idian. Black
or deat	Fun	1 X Never Married 2 N	1 Yes	X No	If Ye	es, specify Cuban, M	lexican, Puerto Ri	can, etc.)	White,		
336 thin 72 hours after ie. than "natural", edical Examiner	by	15 December 1 5 1 11 12	vorced If Yes, Give Year or Dates:	malatad)		Yes 2X No s			Specify: W		
72 hou n "nai	ompleted	Elementary/Secondary (0-12)			during mo	's Usual Occupation est of working life. D	ONOT use retired	k done I)	16b. Kind of Busi	ness/Industr	У
036 vithin ene.	mpl	10			Insta	llation			Floori	na	
15-C	ပိ	17. I dulet 3 Name (Flist, Middle	, Last)		 -		Mother's Name (F	irst, Middle, N	Maiden Surname)	119	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	To B	Jo A. Goins 19a. Informant's Name/Relations	ship (Type Print)		10h Mailine	M Address (C)	ary Jo F	ergusc	on		
MD id 2 sho lith and n 27 is aumatia	-	Keith Goins/Br				Address (Street ar		al Route Num lawn,			ode)
nore, MD 21215-0036 sges I and 2 should be filed within 72 hr nr of Health and Mental Hygene. t: If item 27 is marked other than "n other traumatic event, the Medical E.		20a. Method of Disposition		20b. F	Place of Disposit	ion (Name of cemet	ery,	Tawii,	MD 2120 20c. Location - C	•	State
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Baltimore, permit Pages I an Department of Hea Important: If ite		21. Signature of Funeral Service	Licensee		22. Na	ame and Address of	Facility Harr	7 H. W	itzke's	ESV111	.e, MD
		Jorni (.Kc	dde MOI	442	141	DO OLD CO	lımıhia D	וים ע	1:00++ C	- L R	D 21043
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on odon mic.		Do not enter the	e mode of dying, suc	ch as cardiac or re	spiratory arre	est, shock, or heart	App	roximate Interval ween Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Atheroscle	rotic c	cardiovaso	ular diseas	æ				Death
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760, cate be ex physician he burial	//Medical	X UNPENDED	AMENDED ite	m#23a,	PII,27,pe	rME,G856,6/	7/06 TT				
68760, certificate be nding physic se as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	ne of pregn		I death 3	Ectopic pregnancy		23d. Date of de		
P.O. Box 68 that the death certified by the attending detached for use as:	Physicia	1 Yes 2 No 9 Unit	4 Pregnant at	time of dea	ath =	r (Specify)	copic pregnancy		Month	Day	Year
the de	P	Part II. Other significant conditi	9 Unknown								
	<u>a</u>	_Cocaine use	contributing to death	1 but not res	suiting in the uni	derlying cause giver	in Part I.		pacco use contribut		
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I R	ပ္မို	25. Was case referred to medical				11-		1 Y Yes 2		Yes	2 No
Division of Vital Records, rat or Attending Physician: The law requires after death. al Director: After this certificate has been sted in by the funeral director, page 2 should the control of the funeral director.	B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸 E	R/Outpatient		Death (Check only Nursing Ho		tesidence 6		
n of Jing Ph After th	-	27. Manner of Death	28a. Date of Inju (Month, Day, Yo	rv ·	28b. Time of Inju				ow injury occurred	Other:	
IVISION OF Attend after death. Director:	atio	1 X Natural 5 Pend 2 Accident Inves	ing itigation			1 Yes	2 No				
Divis	Certification:			ury - At hon	ne, farm, street,	factory, office building	ng, etc. 28f.	Location (Str	reet and Number o	r Rural Rout	e Number, City
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Division of Vital I vitending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only	ysician: To the best of my niner:On the basis of exan and manner stated	knowledge nination and	e, death occurred d/or investigation	d at the time, date ar	nd place, and due	to the cause((s) and manner as	started	(1)
To roo	≱⊦	29b. Signature and title of certifier				29c. License nur			_		f
			1 1/	/		O.C.M.E			29d. Date signed (rear)
	-	30. Name and addres of person v			(3a)						
79.0		Jack Titus MD. Depi	uty Chief Medical Ex	aminer	111 Penn	Street, Baltimo	ore, MD 21201				
Sta Registr		31. Date filed (Month, Day, Year) MAY 1 5 21	3 Registrar	s Signature	Ropert	,					

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 13**,** 2006 11:40 A. Gallon. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center Baltimore Towson H Under 1 Year Hours Min. 8. Date of Birth (Month, Day, Year) 1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 216-14-7855 83 Yrs. Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow the Medical Exprisher count be notified at 1 Yes 2 No Mary land Baltimore Perry Hall Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or iteme 23a or 17 F Arlen Road 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If 49s, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Treasurer Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F Richard William Gallon Maud Linthicum Stricklen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is m any Injury or other treum John Criswell/Son-in-law 2421 Willowbrook Road Upper St. Clair PA 15241 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/15/06 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton

22. Name and address of Facility

13. Name and address of Facility

14. Line

15. Signature of Funeral Service Licensee Christina L. Hilton

15. Name and address of Facility

15. Line

15. Signature of Funeral Service Licensee Christina L. Hilton

16. Line

17. Name and address of Facility

17. Signature of Funeral Service Licensee Christina L. Hilton

17. Name and address of Facility

18. Line

18. Christina L. Helton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CVA Physician 2 weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physicien and should be detached for use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical Box (23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospitel or Attenuers within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ng 10051926 May 13,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 660/ N. CHARLES STREET Helsen M. Gordon dus TOWSON MD Registrar's Signature 31. Date filed (Month, Day, Year) State 1 5 2006 Registrar

			For State Registrar	State o	f Marylar		rtment of F		Mental Hy	giene Reg. No. 2	006	15067
	Dharisi		1. Decedent's Name (First, Midd	lle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Kita (Saulin					May	7	2006	OISI AM M
)	Examin	er	4a. Facility Name (If not institution University of		Medical	Center		more		Ball	unty of Death	
2/	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mir		y. Year) 1927	Cau	place (State or Foreign ntry) nsylvania
	anyland ehow	or.	Usual Residence of Decedent 10a. State 10b. Count			ty, Town or Lo	cation					10d. Inside City Limits
	or 28e-f	Director	Maryland Sussex 10e. Street and Number		1 11 1 1	sboro	10f. Zip Code	<u> </u>		10g. Citizen	of What Cou	
	ath w		26579 Anchor Cove				19966				States	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28e-f show strain interests to other traumatic event, the Medical Examinat must be notified at ODGE.	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried Armed For	2 ⊠ No ve		Vas Decedent of F f Yes, specify Cubi I ☐ Yes 21 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No arto Rican, etc.)	-	Race - Ameri Black, White, ecity: Whit	etc.
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<u> </u>	Men Men Marke Marke	၉	Kenneth Charles Hi			401 14 75			Sarah Ferre		Cana 7	- C- d-1
Mar	d 2 sh th and 7 is m		19a. Informant's Name/Relation Karen Beyer	iship (<i>Type, Print)</i>			Coronado C		Rural Route Numb nassas \	er, City or 10 /a 2111		Code)
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ē	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State		natory`or other pla oln Cemeter		2/2006	Brenty	vood, Ma	ryland
Baltimore,	permit. I Departm Importar eny inju		21. Stanfure of Tuneral Service		1.		Name and Addre leck Funera 501 Sandy S		d laurel	MD 2070	07	
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8760,	Physician /Medical Examiner but sicien and physician and physician and physician and physician are the	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consection of the con	quence of): quence of): VQSCI	alar acc		ricular A	espansi		Onset and Death
P.O. Box 687	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	1 Live	utcome of pregn birth 2 Fet nant at time of on	al death 3[Ectopic pregnanc	ý		230	. Date of deliv Month	ery Day Year
	e law requires that the di has been signed by the ye 2 should be detached	þ	Part II. Other significant condi	tions contributing to d	death but not re	sulting in the u	nderlying cause giv	ven in Part I.		obacco use		the cause of death?
Division of Vital Records,	The law ate has t page 2 s	Completed					-		24a. Was auto perfo		24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
/ita	ysicien: Th is certificate director, pag	Be (25. Was case referred to medic examiner?				Lau		eath (Check only	one)		
of \	S S	2	1 Yes 2 No			ER/Outpatier	IL SLI DOA		Home 5 ☐ Resi			ty)
sion	Attending For death. ector: After by the funer	Certification:	27. Manner of Death 1 XNatural 5 Pence Pe	tigation	of Injury oth, Day Year)	28b. Time o	M 1	ry at rk? Yes 2 □ No				
ΟİΧ	s after or all Direct of in by	Certif		minor 289. Plac	e of injury - At r ling, etc. (Speci	ify)	eet, factory, office		City or To	wn, State)	IUITIDEI OI HUI	al Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the cumpletely filled in by the funeral	edical	29a. Certifier 1 Certify (Check only one) 1 Certify	ring Physicien: To th al Examiner: On the I and mai	e best of my kn basis of examin nner stated.	owledge, deat ation and/or in	h occurred at the to vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) an date and pla	d manner as a	stated. to the cause(s)
	To the To the Cumplet	M	29b. Signature and little of certification	u & Rue	5 Mi)	29c. Licens	6693		May 5	igned (<i>Month</i> , 200	
1	2		30. Name and address of person	n who completed at		m 23a) (Type,	Print)	Herrina	MD 2/20	10.0		
	illa and or	ate.	31. Date filed (Month, Day, Yea	r) #82.	Registrar's Sign	ature #	est ba	Thirm (P)	MU ZIZO	,		
	Sta Regist			2006 Siene	as B	ature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4a,17,19a, perMD,FH, 0355,5/15/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** GALPERIN MAY **MENASHE** 2006 8:12 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4104 CENTURY TOWNE ROAD RANDALLSTOWN BALTIMORE | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 09/11/1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 1 M 2 F Yrs LITHUANIA 213-25-6578 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b. County MD BALTIMORE RANDALLSTOWN 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4108 CENTURY TOWNE ROAD 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: WHITE 1 Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MANAGER NURSING HOME 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) GALPERIN BERENSTEIN PINEHAS SARA Pinchas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD - RANDALLSTOWN, MD 21133 4108 CENTURY BELLA GALPERIN / WIFE 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State HAR SINAI CONG. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/12/2006 OWINGS MILLS, MD 21. Signature di Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease of complications that caused the or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or/as a consequence of) Examine Due to (or as a consequence of) Rhysician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hosoital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760 Division of Vital **Funeral**

Director

r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, Ina Maule 2008.

Physician /Medical Examiner

burial-transit

signed by the attending physician d be detached for use as the buria

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director, to

State Registrar

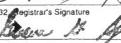
Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 5 2006



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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4

Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MEE

29d. Date sigged (Month, Day, Year)

		•	For State Registrer	-	partment of Health Certificate of Death		iene eg. No. 2006	15069
,	Physicia	an	Decedent's Name (First, Middle, Last)	foldberg	a .	2. Date of Dea Month	th Day Year	3. Time of Death 4. 45 qm
	/Medic Examin	ai	4a. Facility Name (If not institution, give street and r	number)	4b. City, Town, or Location		1 2006 4c. County of Deat	
	Examin	ei S	ARDEN COURTS		BALTIMORE		BALT	IMORE
A 10	Funeral Director	17	5. Social Security Number 6. Sex 17-05-3204 6. Sex	7. Age (In yrs. last birthd 92 Yrs	Months Days Hours	# 24 Hrs. 8. Date of Birth (Month, Day 05/05/1	, Year) Co	hplace (State or Foreign untry) PA
-	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits
	Mary a-f ah	tor	MD BALTIMORE	BALT	IMORE			1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Co	untry?
	eath v		8909 REISTERSTOWN RO		21208	rigin? (Specify Yes or No-	U.S.A.	rican Indian
980	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itama 23a or 28e-f ahow I'lla Medical Examinational be notified at	by Funeral	1 Never Married 2 Married 1 Ye	s 2 K No	 Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☐ No Specify 		Black, White	
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade complete	d) (G	ecedent's Usual Occupation live kind of work done during mo	st of working	16b. Kind of Business/	Industry
Maryland 21215-0036	within iene. then	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	e. DO NOT use retired)		ADVERTISI	NG
d 2	를 찾다 다	Be C	17. Father's Name (First, Middle, Last)		18. Moth	ner's Name (First, Middle,		
ylaı		Tof	MAX	GOLDBI			TRACHTENBE	
	nd 2		19a. Informant's Name/Relationship (Type, Print) MARCY WESALO / DAUGHTE	R 12:	ailing Address (Street and Numb	RTH - OWINGS	MILLS, MD	2111/
Baltimore,	Pages 1 nent of H int: if Ita		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal fro 4 □ Donation 5 □ Other (Specify)	- comotoni	sposition (Name of crematory or other place) DEK CONG.	05/14/2006	20c. Location - City or WILKES BAR	RE, PA
Balt	permit. Departn Imports any Inju		21. Signature of Funeral Service Licensee		22. Name and Address of Factor Name and Address of Factor Name 22. Name and Address of Factor Name 22. Name and Address of Factor Name 22. Name and Address of Factor Name 22. Name and Address of Factor Name 22. Name and Address of Factor Name 22. Name and Address of Factor Name 22. Name and Address of Factor Name 22. Name and Address of Factor Name 22.	ROAD - PIKE	& EROS., I ESVILLE, MD	21208
۳			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	t caused the death. Do not neach line.	. 11			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-ongest		r Failur	e	NOURS
	Examiner		Due	to (or as a eensequence of):	Artery I) isease		Months
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	ate be executed physicien and the burial-transit	Examine	that initiated events c	to (or as a consequence of):				
8760,	sicien buria	dical E	L _d					
9	tificati g phy as the	Medic	IS SERVICE.					
.O. Box	The law requires that the death certificate be executed wie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	in the cast 12 months?	gnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
S, P	es that igned b be deta	by Pi	Part II. Other significant conditions contributing to	death but not resulting in th	ne underlying cause given in Part		bacco use contribute to	- 1
ord	w requir been si should	eted	Alzheimer's	DISTAST		1 Y		obably 4 □Unknown
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Vita	Physicien: 7 this certificer al director, p	Be	25. Was case referred to medical examiner? Hospital:	7.	Other	ce of Death (Check only or		city) ARDEN COURTS
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Division	al or Att s efter de si Direct ad in by t	Certification;	3 Suicide 6 Could not be determined 28e. Pla bu	ice of Injury - At home, farm ilding, etc. (Specify)	, street, factory, office	28f. Location (S City or Town	treet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	Medical ((Check only 2 Medical Examiner: On the	the best of my knowledge, de basis of examination and/danner stated.	earth occurred at the time, date a or investigation, in my opinion, de	and plane, and due to the coath occurred at the time, d	ausa(s) and manher as late and place, and due	to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier	, Onght, N	29q_License number	740	Ped. Date signed (Mont.	1 . 0
1	21		3. Name and address of person who completed of	ause of death (Item 23a) (Ty	pe, Print) Vaney Valle	y Road T	Imonium.	MD21093
W.	Sta		31. Date filed (Month, Day, Year) 32	. Signature	lank.) /		
	Registi	ar "	MAY 1 5 2006	Sherry D.	god -			

	T= For State of Maryland / State of Maryland /	Department of Health and I Certificate of Death	Mental Hygiene Reg. No. 2006	-15070
Physicia	Decedent's Name (First, Middle, Last)	Harrison	2. Date of Death Month Day Year MAY I: ZOO	. 3. Time of Death
/Medica Examine	4 - 5 - 112 - 11 - 112 -	4b. City, Town, or Location of Death BALTIMORE CTY		
Funeral Director	5. Social Security Number 219-62-3286 Usual Residence of Decedent	birthday) If Under 1 Year If Under 24 Hrs.	(Month, Day, Year)	thplace (State or Foreign ountry) kryland
the Maryland 28e-f show notified at	10a. State 10b. County 10c. City, To	own or Location Himore		10d. Inside City Limits
3e or 28e	100. Street and Number 1901 Barelay Street	10f. Zip Code	10g. Citizen of What C	ountry?
permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, I'm Modical Examinating the notified at once.	Maryland NA Baland 10e. Street and Number 190 i Bar alay Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	pecify Yes or No- b Rican, etc.) 14. Race - Am Black, Whi	te, etc.
Althin 14 IICU Ne. "matural Walical E		6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business	•
lid be meu niental Hygier ked other ti ic evant, In	17. Father's Name (First, Middle, Last) Carl Harrisen		ne (First, Middle, Maiden Sumame)	
and 2 should ealth and Men m 27 Is marke har treumatic	19a. Informant's Name/Relationship (Type, Print) La Gray - Mother 1	9b. Mailing Address (Street and Number or Ru 1739 East Baltim	ral Route Number, City or Town, State, ore St. Bullo: M	0 21231
t. Pages 1 rtment of H rtant: If ite	1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	e of Disposition (Name of othery, crematory or other place) 1300 Forvast V.A. May	Date 20c. Location - City of 17, 2006 Owing M	4.
Departin Departin Imports any inju	21. Signature of Funeral Service License	CALVIN L. WILLI	mrs F.S. Bulto,	K 11651 MD 21229
Physician /Medical	23a. Par1. Enter the disease, or complications that caused the death. Description shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HOUTE RESPIRAGE Due to (or as a consequent)	DISTRESS STUDEOUE	or respiratory arrest,	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last b. PNCUMDIA Due to (or as a consequence of the consequence of	ce of):		12 days
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Past II Other significant conditions contributing to death but not resulting	ath 3□Ectopic pregnancy	23d. Date of de Month	livery Day Year
n signed by	Farm. Other significant conditions contributing to death out not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
cate has been si			autopsy prior to performed? death?	utopsy findings available completion of cause of s 2 XNo
Physicu this cer al direct	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Notation investigation 28. Date of Injury (Month, Day Year)		th (Check only one) ome 5 Residence 6 Other (Spe 28d. Describe how injury occurred	ecify)
To the Hospital or Auending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	27. Manner of Death 2	, farm, street, factory, office	28f. Location (Street and Number or R City or Town, State)	ural Route Number,
A Funer	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowled 2 Medical Exeminer: On the basis of examination and manner stated.			
withir To th	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
()	30. Name and address of person who completed cause of death (Item 23: STUART K AMMEN, THE JUHNS HOPKINS H 31. Date filed (Month, Day, Year) 2. Registrar's Signature	OSPITAL, GOD NORTH WOLFE S	IRECT, BALTINORE MARYLI	78 SIS GUA
Stat Registra	7 0000	figure .		

06-03038 Scott Hafner

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Day 0635 hrs **Medical Examiner** Scott Edward Hafner May 5, 2006 4c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 807 North Fulton Avenue Baltimore If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year **Funeral** 218-84-3557 Months Days Hours Director 32 Jan. 11, 1974 Country) MD 1 X M 2 Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits any MD Baltimore 28a-f show 1 Yes 2 X No s 23a or 28a-f shov e notified at once. Lansdowne with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 2504 Gehb Ave 21227 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc 1 X Never Married 2 Married Yes 0 more, MD 21215-0036

Pages I and 2 should be filed within 72 hours after d nent of Health and Mental Hygiene and I filen 27 is marked other than "natural", or rother trannatic event, the Medical Examiner. Specify: White Yes 2 X No specify Divorce If Yes, Give Yea 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Technician HVAC 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) David B. Hafner Vicki L. Wehberg Be 19a. Informant's Name/Relationship (Type, Print) Vicki L. Wehberg/Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4209 Spring Ave Halethorpe MD 21227 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition 20c. Location - City or Town, State Baltimore, crematory or other place) Pages 1 tment of 1 xBurial 2 Cremation 3 Removal from State New Cathedral Cemetery May 8, 2006 Baltimore, MD 4 Donation 5 Other Specify! 9 22. Name and Address of Facility Ambrose 2719 Hammonds Ferry Rd. 1. Signature of Funeral Service Licensee Funeral Home Lansdowne MD 23a. Part I. Enter the disease death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval or complications that caused the **Physician** failure. List only one cause on each line Between Onset and /Medical Death Narcotic intoxication Immediate Cause (Final disease a. Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. iner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Physician/Medical AMENDED item#23a,27,28a-f,perME,g855,5/25/06 TT [X] UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes ٩ 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No 5 Pending Fnd 5/5/2006 death Fnd 6:30 AM 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 807 North Fulton Ave. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide determined (Specify) found at residence Baltimore, within 24 hours a 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal one) 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. May 5, 2006 eted cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

State Registra

31. Date filed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #20c Per FH G855 5/15 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** becc 2 a 0 2006 /Medical acility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner WN 15 nWe a MOTE 9 and O If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 M 2 X F Yrs. Director 220-12-2922 82 Maryland 03/17/1924 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1802 Eutaw Place 21217 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) othar than Elementary/Secondary (0-12) College (1-4or 5+) 8 Security Guard Security 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumetic event 18. Mother's Name (First, Middle, Maiden Sumame) William Young Henrietta Whalen 19a. Informant's Name/Relationship (Type Print) ASSISTED Liv-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 Eutaw Place, Baltimore, Maryland Camille Matthews /ing Director 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Pikesville Pilesville, 1 □Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery 05/15/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilithe Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Laltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 0 /Medical Due to (or a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Year Month Dav signed by the aid be detached for 4 Pregnant at time of death 5 Other (specify) JYes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 20 No 1 Yes 1 ☐ Yes 2/2 No or Attending Physician: Be 25. Was case referred to medical examiner? Subacute unit 26. Place of Death (Check only one) 1 Yes 2/1 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident M completely filled in by the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funarai 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) we 2006 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Road me Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 1 5 2006

Millard	Benjamin	Hall	

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	- 1	1- For State Certificate of Death	Reg No. 200	6 1507
Physici	an/	Decedent's Name (First, Middle,Last)	Date of Death Month Day Year	3. Time of Death 0022 hrs
Medical Exami		Millard Benjamin Hall 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 3, 2006	
		5107 N. Englewood Dr. Capitol Heights	Prince Georg	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.		
Director		unk 1 X M 2 F 61 Yrs. Months Days Hours Min.	June 10, 1944 C	gn puntry) NC
	ŀ	Usual Residence of Decedent	pulle 10, 1944	
' any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Maryland 28a-f show 1 at once.	ō.	MD Prince Georges Capitol Heights		1 Yes 2 X No
Maryl 28a-i d at c	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Cou	intry?
ith the Maryland 23a or 28a-f sho notified at once.		5107 N. Englewood Drive 21024	IISA	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		rican Indian, Black,
ter des		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify 1, 1	
hours afte "natural", Examiner	d b	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of w	vork done 16b. Kind of Business	ack /Industry
5 72 ho m "ma	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retir	red)	
5-0036 led within 72 Hygiene. other than '	Ē	3 none Laborer	Domestic	
15-C			(First, Middle, Maiden Surname)	
21215-0036 ould be filed within 7 the Mental Hygiene. s marked other than ic event, the Medical	o Be	Ash1ey Hall Ernesti 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or R	Lne Lyons Rural Route Number, City or Town, Stat	e. Zip Code)
and 2 shou sealth and N		Ashley J. Hall/brother 6304 Knightdale-Eagle	Rock Wendell NC	27591
more, MD 21215-0036 Pages I and 2 should be filed within 72 tent of Health and Mental Hygiene. Int: If item 27 is marked other than " In other traumatic event, the Medical	- 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City of	
nore		Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:		
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra	1	21 St. in Mare of Funeral Service Licensee 22 Name and Address of Facility		
ii ii De in		Romald S Wash Sirector State Anatomy Boar Baltimore, MD 2120	d 655 W. Baltimor	e Street
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) A Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):		Death
		b.		
	声	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use to (or as a consequence of):		-
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e exec cian ar rial - t	edical	UNPENDED AMENDED		
f760, ficate be executed g physician and the burial - transit	- ≥	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delive	
Sox 687 death certiff e attending I for use as I	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	nncy Month	Day Year
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		
s, P.O. Bairies that the designed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ires th	d by		1 Yes 2 No 3 Pro	bably 4 Unknown
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tal Recinant The certificate ector, page	Be	25. Was case referred to medical 26 Place of Death (Check of		
Vita hysici this c	To B	Tes z No	g Home 5 Residence 6 🗸 Oth	er: Scene
Ision of Vital Rec Attending Physician: The I or dear. After this certificate I by the funeral director, page	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 ✓ Natural 5 □ Panding	28d. Describe how injury occurred	
ivisior or Attendafter death Director:	Satic	2 Accident Investigation	000	
Division of Vital Records, P.O. Isla or Attending Physician: The law requires that the sale free death. To all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detack	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	ural Route Number, City
lospita I hour unera Iy filk		4 Homicide	due to the cause(s) and manner as str	rtod
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	• • •	
To To	Me	and manner stated. 29b-Signature and title of certifier 29c. License number	29d Date signed (M	onth, Day, Year)
		1 St. (him - tolle O.C.M.E.	May 3, 2006	
		30 Name and address of person who completed cause of death (Item 23a)		
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimor	e, MD 21201	
S Regis	tate			

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			1 _ State	State of Ma		artment of He <i>rtificate of D</i>			2006	15071
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	Physici	an						Month .	Day Year	
	/Media		Dorothy 4a. Facility Name (If not institution, gi	Howard		4b. City, Town, or L		May 1	4c. County of De	
	Examir	er	Baltimore Washin		1 Center	Glen Bu			Anne A	
	Funeral	-	5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Director		044-12-8126	1□M 2(XF	93 Yrs.	Months Days	Hours Min.	(Month, Day, Y Sarch 26	1913 N	rthplace (State or Foreign country) ew York
	p ,		Usual Residence of Decedent		10. 0". T					
	aryla shov	7	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	88e-1	Directo	Maryland Anne A	rundel	Oder					1¶Yes 2 No
	with the second					10f. Zip Code			. Citizen of What (•
	d within 72 hours after death with the Maryland jene. r then "naturel", or Hems 23e or 28e-f show the Modical Esculier out the Incilled at	Funeral	2304 Snowflake D:	12. Was Decedent I	Ever in IIS 13	Was Decedent of Histo			Inited St	
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21215-0036	within 72 ene. then "nai	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done dur DO NOT use retired)	ing most of workin	g		
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Maryland	0 2 2 0		19a. Informant's Name/Relationship			ng Address (Street and				
_	s 1 and if Health item 27 other tr		William J. Howard	1/son		Snowflake			Maryland c. Location - City o	
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г			23a. Part 1 Enter the disease, or con shock, or heart failure. List only	plications that caused	the death. Do not ent	11 Annapol	LIS KOAU such as cardiac or	respiratory arrest	, Maryia	Approximate
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	/Medical		disease or condition resulting in death)	a. Due to (or as						10 gens
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7	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	nderlying cause given i	in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
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5	ding Ph h. After th funeral		27. Man r of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work?		d. Describe how		
Mision	ttendil feath. tor: A the fu	catle	2 ☐ Accident investigatio	n		M 1 ☐ Yes	2 □ No			
Ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office	28	If. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
ב	urs a		00- 0				N.			
	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example one)	nysician: To the best on miner: On the basis of and manner state	examination and/or inv	occurred at the time, estigation, in my opinion	date and place, an on, death occurred	id due to the caus I at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier	And mariner star	Λ.	29c. License nu	umber	29d.	Date signed (Mont	h. Dav Year)
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	4	-	30. Name and address of person white	completed cause of de	ath (Item 23a) (Tyne 1	Print) 1 . ^		1 -		
	3		30. Name and address of person who	M M.D.	301 K0	spital D	rive &	len Bu	rule, MD	21061
E Age	Sta		31. Date filed (Month, Day, Year)	32. Pojistra			*			
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Howard, Dovothy

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32/Registrar's Signature

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31. Date filed (Month, Day, Year) MAY 1 5 2006

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1- State Ragistrar Amend ITEM #20b Per FH G8550 Sylfip #06 of ID eath Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marie Jackson 9:30 AM March 8, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing Home Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1□ M 2√X Yrs. 578-46-4312 Washington DC Director May 13,1933 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shoy dical Examiner must be notified at Maryland | Prince George's ¥ Yes 2 No Oxon H111 Director Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with ò 1405 Southern Avenue Apt 102 20748 United States 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ₩ Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. the May Elementary/Secondary (0-12) College (1-4or 5+) Twe1th Clerk Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fand Mental Figure 1 and Mental Figure 1 Arthur B. Taper Jessie Mae Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; if Itam 27 Ia n any Injury or other traun Carlos Juan Ginyard/Son 3901 Suitland Road #508, Suitland Maryland 20476 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3/29/2006 Riverdale Crematory * 4 □ Donation 5 □ Other (Specify) Riverdale Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Fineral Service Licensee 1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer of Uterus /Medical Due to (or as a consequence of): Examiner Gastrointestinal Bleeding Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Urosepsis and Due to (or as a consequence of): Box 68760 physician Physician/Medical the as ding 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery for us 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 Tyes Division of Vital 343XNo Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 4√2 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification; Injury at Work? After To the Hospital or Attending 1 Naturat 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD8172 3-13-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khosrow Davachi MD 1328 Southern Avenue SE #310. Washington DC 20032 31. Date filed (Month Day 1 Year) 2006 . Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:00 P M Physician 2000 0 OhNSON dward /Medical 4c. County of Deal 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner H Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 4402 Hall Marble Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** M 20 F 213-54-42 Mid Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County or 28a-f show item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Kaltimore Md Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 Hall Rd #293 4402 Marble Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Co. Of Balto L.T.O. Elementary/Secondary (0-12) College (1-4or 5+) Shoreman 12+h permit Pages 1 and 2 should be file.
Department of Health and Mental Hygh Important: If Item 27 is marked in one, injury or other the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sr. E'dward Ralph largaret Johnson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 3616 SkipJack Ct. Abingdon, MD 21009 andia rot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 16/06 Woodlawn Md woodlawn Constery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatruan - Harris Funzal Home 21. Signature of Funeral Service Licensee 5240 Raisterstown Rd Baltimore Md 21215 arus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lerebrovascular Disease /Medical Due to (or Examiner Altery Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Physician/Medical attending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 □ No 3 □ Probably 4 □Unknown Hypelipidemia ype tension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy Deep Venos thrombosis
S. Was case referred to medical certificete of Vital 26. Place of Death (Check only one) director, Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No this 28a. Date of Injury (Month, Day Year) After thi funeral of 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation Division 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 5-12-06 H 00 59388 Veisman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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Dourd Weisman, 31. Date filed (Month, Day, Year)



Lock Rover

Baltimore

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			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment o			Mental Hy	/giene	06	15078
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	Physici /Medio		Hazel	Μ.	Johnson				Month	Day 11 20	Year N6	6:00 A M
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2		A	14416 Manor Roa				enix			Ba1	timor	е
	Funeral		5. Social Security Number 6. Se 200-03-2738	x 7.Age □M 2D X F	(In yrs. last birthday) Yrs.	If Under 1 \ Months E		Under 24 Hrs. Hours Min.	(Month, D	irth ay, Year)	Cou	place (State or Foreign ntry)
1	Director		Usual Residence of Decedent		93_ ^{*rs.}				Dec. 9	, 1912	West	Virginia
	yland how		10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside City Limits
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	or 28	Director	10e. Street and Number			10f, Zip Co				10g. Citizen of		•
	s 23a		14416 Manor Road			211					J.S.A	-
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Baltimore,	permit. Pages Department of t Important: If its eny injury or of		21. Signature of Funeral Service Licens	99	22	. Name and A	Address o				-	Home, Inc.
<u>-</u>	82559		Tank Hap	e	1	050 Yo	rk Ro			Maryland		
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	it the death certificate by the attending phys tached for use as the	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death 5	Other (special	fy)	-		M	onth	Day Year
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	To the Hospitel or At within 24 hours after or To the Funerel Direc completely filled in by	Me	29b. Signature and title of certifier	<u> </u>		29c. Li	icense nu	ımber		29d. Date signe	ed (Month,	Day, Year)
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	5		Luisa Massari		346 Paper	Mill R	oad	Phoer	iix, Mar	yland	21131	
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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Asiden Sumame) 19. Mother's Name (First, Middle, Asiden Sumame 19. Mother's Name (F		1	\ •	For State Registrar	State of Ma	aryland		rtment <i>tificate</i>				lental Hy	giene Reg. No.	0 (36	15079
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Physician Medical Examiner Part Condition Part P	The state of the s	2		23a. Part 1. Enter the disease, or	complications that ceuse	d the death	n. Do not ent	er the mode	ST of dying	St. g, such as	Ann cardiac	or respiratory	arrest,	Q. <u>.</u>	2141	Approximate
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24a. Was an autopsy available proformed of death? 25. Was case referred to medical examiner? 26. Place of Death [Check only find] 27. Was an autopsy findings available profor completion of cause of death? 28. Place of Death [Check only find] 28. Place of Death [Check only find] 28. Place of Death [Check only find] 28. Place of Death [Check only find] 28. Date of Injury at Work? 28. Place of Death [Check only find] 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 29. Certifier [Check only 2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. City or Town, State) 29d. Date signed (Month, Day, Year)	o,	s thet i gned by se deta		Part II. Other significant condition	ons contributing to death I	but not res	ulting in the น	nderlying ca	ause give	n in Part	1.				1 -	
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 Fr/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural 1 Matural 5 Pending Investigation 1 Yes 2 No 2 No Name and address of person who completed cause of death (Item 23a) (Type, Print) 28. Date of Injury at 28c. Injury at North 28c. Injury at Nort	ord	equire sen si sould b										1	Yes 2L			
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Registrar MAY 1 5 2006 Agree & Cooks	100			31. Date filed (Month, Day, Year,	32.	-		and !	9							

MICHAM KOSOS 06-03099 **UNK UNK**

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day 7, 2006 2245 hrs Medical Examiner Richard Nicholas Koros 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel N. Ritchie Highway, Marley Station Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Country) MD Months Days Min Hours Director 42 Aug. 3, 1963 215-96-3563 1 X M 2 F Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Auk is 23a or 28a-f show s e notified at once. Glen Burnie 1 Yes 2 X No Anne Arundel MD Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 884 21060 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. or items must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No White 1 Yes 2 X No specify: If Yes, Give Year 4 Divorced Specify 3 Widowed à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 hours in nent of Health and Mental Hygiene ant: If item 27 is marked other than "natura 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical Baltimore, MD 21215-0036 N/A Disabled 8 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Street and Number or Raral Route Number, City or Town, State, Zip Code) John Stanley Koros Be 19a. Informant's Name/Relationship (Type, Print) Elizabeth Koros - Mother Date 20c Location - City or Town State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Burial 2 X Cremation 3 West Arunder Department of Important: It 5-13-2006 Chematory Odenton, MD Other Specify Ponation 5 Funeral Service L Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical a Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Discass or Injury that initiated events resulting in death) Last Due to (or as a consequence of): ransit transit The law requires that the death certificate be executed sician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Year Fetal death Month Day 21 Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ 1 Yes 2 No 3 Probably 4 Unknown ۵. Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? page 2 ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica 26 Place of Death (Check only one Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene this ို 1 🗸 Yes 28a. Date of Injury (Month, Day Year) May 7, 2006 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Deceased pedestrian crossing road, struck by 2239 hrs Natural 1 Yes 2 V No within 24 hours after death. To the Funeral Director: filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town. State determined North Ritchie Highway/ Marley Station Rd, Glen (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cert 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. 0 106 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

	1	State of Maryland			of Health and of Death	R	eg. No.	13061
Physicia	n	1. Decedent's Name (First, Middle, Last) Joan Kathryn Klein				2. Date of Dea Month	th Day Year 13. 2006	3. Time of Death 11:30 PM
/Medica Examine		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cent	er	4b. City, Tov	vn, or Location of Dea	ath	4c. County of Dea	
Funeral Director	. 4	5. Social Security Number 6. Sex 7. Age (In yrs. II	ast birthday)	If Under 1 Y Months D	ear If Under 24 Hr ays Hours Mir		9. Bir 9. 941 Ma	hplace (State or Foreign Tyland
70	20	104. 01410	Town or Local					10d. Inside City Limits 1 ☐ Yes 2 No
with the Nia or 28a-f	Direct	10e. Street and Number 8700 Summit Avenue		10f. Zip Co	de 234		10g. Citizen of What Co	puntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Modical Examination allied at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Deceden f Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	(Specify Yes or No- orto Rican, etc.)		
21215-0036 d within 72 hours aft giene. or than "natural", or it to modical exert	ompieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	lent's Usual C kind of work of DO NOT use i maker	ocupation fone during most of w etired)	rorking	16b. Kind of Business	,
land 2	To Be Co	17. Father's Name (First, Middle, Last) Harry George Bayley				ame (First, Middle, rgaret		rlo
Maryland and 2 should be file alth and Mental Hy 27 is marked oth or traumatic svent		19a Informant's Name/Relationship (Type, Print) LeRoy G. Klein, Srhusband			it Ave., E			•
Baltimore, bermit. Pages 1 at Department of Hea mportant: If them any injury or othe		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	rkwood	sition (Name natory or othe cemet	ery 5/	^{/19/06}	20c. Location - City or Baltimore	e, MD
Balti permit. Departir Importa sny inju		MU	1	050 Yo	rk Rd., To	wson, MD	on Funeral 21204	Home, Inc.
bhysician and Examiner transit sthe buriel-transit	ai Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequ	MONAF uence of): uence of):					Approximate Interval Between Onset and Death
Records, P.O. Box 687 The law requires that the death certificate te has been signed by the attending phy- age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Unknown 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 1 □ Live birth 2	Ideath 3	Ectopic preg			23d. Date of de Month	olivery Day Year
ds, P. uires that to signed by tid be detail	d by Ph	Part II. Dther significant conditions contributing to death but not res	ulting in the u	nderlying cau	se given in Part I.		obacco use contribute (es 2 No 3 F	to the cause of death?
Vital Records, sicien: The law requires t certificate has been signe rector, page 2 should be or	Completed by	ANEMIA OF CHRONIC DISEASE CORONARY ARTERY DISEASE				24a. Was autor perio 1 \(\subsection \) Yes	rmed? prior to	utopsy findings available completion of cause of s 2 \(\text{No} \)
Vital sician: certifica irector, p	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA	Other	Death (Check only o		ecify)
IVISION or Attending iffer death. Director: Afte in by the fune	Certification:	27. Manner of Death 1 XNatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At h. building, etc. (Specification)		M	Injury at Work? 1 Yes 2 No		now injury occurred Street and Number or F vn, State)	Rural Route Number,
DIVI To the Hospital or At within 24 hours after Completely filled in by	edical C	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knd one) 1 Medical Examiner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at evestigation, in	the time, date and pla my opinion, death or	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	n 23a) (Tuno	D D	37254		29d. Date signed (Mor	nth, Day, Year)
Ų sta	ate	30. Name and address of person who completed cause of death (Iter BOON FOH IM, M.D., 76.01 31. Date filed (Month, Day, Year) 32. Registrar's Signary 13. Date filed (Month, Day, Year)	OSLER		E, TOWSO	N, MARYL	AND 2120	4

			For			nd / Depa	artment (of Health and of Death	-	/ / / / /	15082
			Registrar				tinoate	Or Douter	2. Date of D	Reg. No.	3. Time of Death
	Physici /Medic		Decedent's Name (First, Middle, Last	Rosen	nary Ka	lynych			Month May	Day Year 7, 2006	8:44 A ^M
	Examin	er	4a. Facility Name (If not institution, give	e street and nu	mber)		4b. City, To	wn, or Location of Dea	ith	4c. County of Dea	ath
16		e .	Joseph Ritchey H	ospice	Ctr.			altimore C		N/A	
· ·	Funeral Director		5. Social Security Number 6. S 1 220-24-3429	ex □M 2☐xF	7. Age (In yrs	. last birthday) Yrs.	Months [Year If Under 24 Hr Days Hours Min	. (Month, D	orth 9. Bi (2, 1927)	rthplace (State or Foreign Country) Maryland
	D		Usuat Residence of Decedent								
	rylan how		10a. State 10b. County West		10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	within 72 hours after death with the Maryland ane. then "natural", or itams 23a or 28a-f ahow he Madigal Examiner must be notilled at	Completed by Funeral Director	Virginia Berkel	ey			Bun 10f. Zip Co	ker Hill		10g. Citizen of What C	1 □ Yes ⅔ᡚ No country?
	3a or		28 Scotch Pine	Drive				25413		United S	tates
2	leath ms 2:	era	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Deceder	nt of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or N	o- 14. Race - Am	
2 10	fler of	듄	1 Never Married 2 Married	Armed Fe 1 ☐ Yes	2 X No				rto Rican, etc.)	Black, Wh	ite, etc.
4	urs a	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ive Dates:		1 ☐ Yes 28	No Specify:		Specify:	White
70	2 ho	ted	15. Decedent's Ed	ducation		16a. Dece	dent's Usual (Occupation		16b. Kind of Busines	
215	hin 7 In °n Med	ble	(Specify only highest gra	College (life.	DO NOT use	done during most of wo retired)	UIKIIIY		
27		no.	Ukn.			Waitr	ess			Food Ser	vice Industry
7	be filed ntal Hygid od other avent, L	Bec	17. Father's Name (First, Middle, Last)							e, Maiden Sumame)	
lan I	Aenta Aenta rked tic s	To	Francisco Salvi	.no				Lott	ie Butle	er	
ary o	s 1 and 2 should be f f Health and Mental I ftam 27 is marked of other traumatic ave	_	19a. Informant's Name/Relationship (19b. Maili	ng Address (S	Street and Number or F	Rural Route Numi	per, City or Town, State,	Zip Code)
OZ	alth a		Mrs. LaVerne Lewi	s (Daug	ghter)	2714	l Kirk	leigh Road	l Dunda.	lk, Marylan	d 21222
ř.	s 1 a f He itam othe		20a. Method of Disposition			Place of Dispo	osition (Name	of er place)	Date	20c. Location - City of	r Town, State
₽ €	permit. Peges Depertment of Important: if it any injury or o once.		t Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific					Jesus Cem.	5/11/20	06 Dundal	k. Maryland
alti	permit. Peg Depertment Important: i any injury o		21. Signature of Funeral Service Licer			22	Name and	Address of Facility			
E E	Ded fing gny		> Stephenie	m.	assu		uda-Rud	se Ave. D	Home of	Dundalk, I	nc. 21222
41			23a. Part1. Enter the disease, or com shock, or heart failure. List only		caused the dea	at on on ent	ter the mode of	of dying, such as cardia	ac or respiratory		Approximate Interval Between
	Dhysisian		Immediate Cause (Final	one cause on	each line.	100	_				Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	(or as a conse	ICIV (Canc				2 years
	Examiner			50010	(0) 43 4 00/136	querios or,					
4	**	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consu	iquenca of):					
	ite be executed ysicien end ne buriat-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
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2 ×	leath certificate attending physi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant		itcome of pregi					23d. Date of de	elivery
> 0	atte	clai	in the past 12 months?		birth 2 ☐ Fe nant at time of		□Ectopic preg □ Other (spec			Month	Day Year
0	thet the d ed by the detached	isk	9 ☐ Unknown	9□ Unkr	nown						
≥ .	The low requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	y P	Part II. Other significant conditions of	contributing to c	death but not re	sulting in the u	inderlying cau	se given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
\sim sp.	uires n sign	d by	Lung Car	reit					1 🗆	Yes 2□No 3□F	robably 4 Tunknown
4 0	w requir been si should I	Completed	Coronam	calena	- dise	ese			24a. Wa	s an 24b Were a	utopsy findings available
₹ §	ne le e has	Ę		CNIFUY	WIS				auto	opsy prior to ormed? death?	completion of cause of
a			05 11/22	V					W. C. C. C. C. C. C. C. C. C. C. C. C. C.		s 2 No
Q 5	Physician: r this certific ral director,	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Janetiant Of	7.50/0		Other	eath Check only		hospice
4	ਦੇ ਦੋਵ	5	27. Manner of Death			28b. Time o		4 Nursing	Home 5 ☐ Res	idence 6 Other (Sp	ecity) Tu gri
E N sion	ding I h. After funer	盲	1 Natural 5 Pending		of Injury oth, Day Year)	Injury	м	. Injury at Work? 1 ☐ Yes 2 ☐ No			
M is	Attending r death. actor: After	lca lca	3 Suicide 6 Could not b	e Jan Blac	e of Injury - At	home, farm, st	reet factory o		28f. Location	(Street and Number or F	Rural Route Number.
Division of Vita	i or Att after d Diract I in by	Certification;	4 Homicide	build	ling, etc. (Spec	cify)	7,		City or To	iwn, State)	
8	To the Hospital or Att within 24 hours after d To the Funeral Diract completely filled in by		29a. Certifier 1. Certifying Ph (Check only 2 Medical Exar	nysician: To th	e best of my kr	nowledge, deat	h occurred at	the time, date and place	e, and due to the	cause(s) and manner a date and place, and du	as stated.
	the the the f	Medical	one)	and mar	ner stated.						
	To Tool	4	29b. Signature and title of certifier) -			29c. l	icense number		29d. Date signed (Mor	iiii, Day, rear)
	-1		Houn F	ww	~ ANO	7	(6	136011		5/5/04	0
	M		30. Name and address of person who	dompteted cau	se of death (Ite	em 23a) (Type,	Print)	HAMMING O	ST	2 A1/ +1/11 /	2F. 21225
_	- \		31. Date filed (Month, Day, Year)	THURN	J / M/) Registrar's Sigr	SUU (0	רו שעטווינו	0)	DUICHINOR	-E CILLS
	Sta Regist		MAY 1 5 20	06	CASA A	3. Figure	MEL				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 15083 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year **Physician** MAY 7:35 AM 14 2006 Anne B. Larkin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE. N/A HEALTHCARE. ST. AGNES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 K F Months 84 15, Nov. 1921 Maryland | Director 213-18-7115 Usual Residence of Decedent the Maryland 10c City Town or Location 10d Inside City Limits 10a State 10h County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director **Baltimore** Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 11 Department of Health and Mental Hygene. Important: If item 27 is marked other then "natural, or Itema 23e or 21 enty injury or other traumatic event, Ital Meditines. 1222 Tugwell Drive 21228 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Owner** Card Store 11 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname, William E. Imhoff Bertha Nolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Larkin - Dau.-in-law 14200 Dove Creek Way #105, Sparks, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-16-2006 Baltimore, MD London Park Cemetery Donation 5 ☐ Other (Specify) Funeral Service Licen 21. Signal 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aspralia Immediate Cause (Final 3 Weeks **Physician** preunona resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RHEUMATOSA ARTHRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this cr 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Division 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funaral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) il e 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Msam", M.D. P-18613. MAY, 14, 2006. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 CATON AVE. BALTIMORE, MD - 21229 MUHAMMAD SAIM, M.D. 37 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 5 2006 Registra

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		-	For State Registrar	State of M	laryland	/ Depa	artmen tificate	t of He	ealth a Death	ınd Me		giene)	006	15084
	Physici	_	Decedent's Name (First, Middle, Last) ON ATHAN					Lo	DEN		Date of Dea Month	Day	Year 2006	3. Time of Death
*	/Medic	- 46	4a. Facility Name (If not institution, give s	treet and number)		4b. City,		Location of		VIN I		unty of Death	
			THE JOHNS HOPKINS				BALT If Under		E CI		Date of Die		0.0	-la (Chana a Farin
	Funeral Director		5. Social Security Number 6. Sex 123 - 76 - 2229	M 2 F	ge (In yrs. la: 33	Yrs.	Months	Days	Hours	Min.	Date of Birt (Month, Da)	y, Year)	973 Ma	nplace (State or Foreign untry) aryland
	0		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation							10d. Inside City Limits
	f sho	tor	Maryland Howard			cott								1 ☐ Yes 2 🛣 No
	or 28a	irec	10e. Street and Number		DILL	COLL	10f. Zip	Code				10g. Citizer	of What Co	untry?
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336	urs eiter de el', or Itemi	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 XYes 2 If Yes, Give Year or Dates:	? No		Was Deced If Yes, spec			gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		Black, White	e, etc.
21215-0036	permit. Pages 1 and 2 should be lided within 72 hours eiter death with the maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Instrument of Heelth and Mental Hygiene enyt injury or other traumatic event, the Musical Examination to the religion along.	Completed	15. Decedent's Edu (Specify onfy highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or	5+)	(Give	dent's Usua kind of wor DO NOT us Sales	rk doné d se retired)	tion uring most	of working			of Business/l	industry
g 5	Hygie other t	ပိ	17. Father's Name (First, Middle, Last)				Sales		18. Mothe	r's Name (First, Middle,			
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Maryland	h and 7 is mu		19a. Informant's Name/Relationship (Ty		3						Route Numbe			
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ë i	Page nent o ant: # ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	9	t Law	n Mem	. Ga	rden					ille, MD
Baltimore,	Departition of the control of the co	21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, M												
	Physician		23a. Part1. Enter the disease or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that cause se cause on each				e of dying	g, such as o	cardiac or i	respiratory ar	rrest,		Approximate Interval Between Onset and Death DA
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W	ted nsit	Examiner	squaritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ence of):		۸. ۸	65 TA	W.Ch.	_			2 YEARS
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<u>a</u>	es tha igned be de	þ	Part II. Other significant conditions con	ntributing to death	but not resul	ting in the u	inderlying c	ause give	on in Part I.		1	obacco us <i>e</i> Yes 2□i		the cause of death?
Œ	The ate h page	Completed									24a. Was autop perfo 1 Yes		24b. Were au prior to death?	topsy findings available completion of cause of 2 \square No
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n of	Attending Physicien: r death. scfor: After this certificator, by the funeral director.	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	iury :	R/Outpatier 28b. Time o Injury		28c. Injury Work	4 140	28	e 5 Resid d. Describe I			eny)
Division		ertification:	3 Suicide 6 Could not be determined	28e. Place of li building,	njury - At hon etc. <i>(Specify)</i>	ne, farm, st	reet, factory	y, office		28	f. Location (S City or To	Street and f vn, State)	Number or Ru	iral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami		of examination									
	within To th	ž	29b. Signature and title of certifier	MEDICAL	DOCT	Λp		c. License					signed (Monti	
•			Monika Burness					KES-	000			MAY	2, 200)6
	10+1		30. Name and address of person who come MONIKA BURNESS, THE JO	HNS HOPKIN	5 HOSPI	ITAL (600 NO	RTH W	OLFE	STREE	T BALTI	MORE N	MARYLAN	ID 21287
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 5 200	States	strar's Signati	100	Me)							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 09 v300Winifred Lee Ledoux 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution; give street and number) Examiner Baltimore 5+ Hospital Agres If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 19, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X Hours Months Days Min. 63 Yrs. 1942 Maryland Director 218-44-0065 Nov. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County erthen "natural", or Iteme 23a or 28a-f ehow The Medical Examinar must be notified at 1 ☐ Yes XXNo Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 3517 Font Hill Drive 21042 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. e filed within 72 hours efter all Hygiens. I other then "natural", or Itel 1 □ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specity: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) of America 4 Department of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H ၉ Walter Theodore Sermons Nettie Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 le rr eny Injury or other treum QDCs. 3517 Font Hill Drive; Thomas J. Ledoux (Husband) Ellicott City, Maryland 21042 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Permetion 3 Removal from State Loudon Park Cemetery May 12,2006 Baltimore, Maryland

22. Name and Address of Facility Loudon Park Funeral Home
3620 Wilkens Avenue
Baltimore, Maryland 21229 4 □ Other (Specify) 4 Donation Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician pneumonia
Due to (or as a consequence of): weeks disease or condition resulting in death) /Medical **Examiner** cancer year breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown as been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pleted 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has Com 1 Yes 2 No ofter death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauca(e) and manner as stated. 29s. Cartifiar Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 15243856-3530 surgial Resident May 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jaret E Mallulieu , DO. 900 coton Ave. Baltimer MD 21229 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 1 5 2006 Registrar

ecax, winifred

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 10, 6:40AM M **Physician** 2006 Mae Elizabeth Luebben /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 6023 Alta Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 21, 1932 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 □ ¥F Months Hours MaryTand 74 216-28-9289 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-1 show raumatic event, the Madical Examinar mast he notified at 1**V** Yes 2 □ No Baltimore N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21206 6023 Alta Avenue Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If them 27 is marked c 8 Constance Mathias Schellenschlager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6023 Alta Avenue Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type, Print) Bernard A. Luebben- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/13/06 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 Cat le 23a. Part 1. Enter the disease, or complications that caused the death. Do not a fer the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine physicien and s the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknow ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing/o deat that of resulting in the underlying cause given in Part I. δ Records, 1 🗌 Yes 2 No 3 Probably 4 □Unknown should | Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1□ Yes 2□No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 esidence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Director: After th 27. Magner of D th 28a. Date of Injury (Month, Day Year) 28d. escribe low injury occurred 28b. Time of Injury at Work? Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 | Homicide ō within 24 hours at To the Funerel D completely filled in To the Hospital The sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certi 30. Name and address of ulis 31. Date filed State 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 0.00 15007

			,	C	ertificate of	Death		Reg. No.	D	100	01
	Di di in	1. Decedent's Name (First, Middle, La	est)				2. Dete of Dea	ath Dey	Year	3. Time of	Death
Н	Physician /Medical	GENEVIEVE	DORIS	MCGAF			May 6,	200		5:50	PM
	Examiner	4a Facility Neme (If not institution, git St. Joseph Nursi			C	4b. City, Town, or l Catonsvil	le	Bal	timor		
	Funeral Director	219-10-9777	Sex 7. Age (In 1□ M 2□ F 8	yrs. lest birthda 6 Yrs.	y) If Under 1 Year Months Days		8. Date of Birt (Month, De) 9/7/191	y, Yeer)	9. Birthpl Count MD	ace (Stete o	or Foreign
	pue *	Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10	d. Inside C	ity Limits
	28a-f sho office a		nne Arundel	L	inthicum			10g. Citizen of W	/hat Count		2√0 √No
	ofter deeth with the Marylen r terms 23a or 28a-f show ofter must be northed at	10e. Street end Number 621 Gayle Drive				21090		τ	Jnite	d Sta	tes
980	Z 2 2 -	11. Meritel Status 1 □ Never Married 2 □ Married 3 □ Twidowed 4 □ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes ♣ ♣ No If Yes, Give Year or Dates:	in U,S. 13	B. Was Decedent of I If Yes, specify Cub 1 ☐ Yas 2 ☑ No		o Rican, etc.)		e - America k, White, e : Whi	etc.	
Maryland 21215-0036	led within 72 hours e lygiene. The matural, of the Medical Exert Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondery (0-12)		(Gi	redent's Usual Occu ve kind of work done DO NOT use retire PhotoSupe	during most of wor d)	king	16b. Kind of Bu	siness/Ind	ustry	
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, Mary	d 2 shuth and 7 is muturn	19a. Informant's Neme/Relationship Shirley Mulheri	n / Daughter	621	iling Address <i>(Str</i> ee Gayle Dri		nicum MD	21090			
Baltimore,	w == =	20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 [4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, ci	position (Name of rematory or other pla v Cremator	y 05/9	Date / 2006	Baltimo			nd
Balt	permit. Page Department of important: If any injury or pnce.	21. Signature of Funeral Service Lice	Victor P.	Doda, Jr	22. Name and Addr Charles 1501 Ea	ess of Fecility 5 L. Steve 1st Fort 1	ens Fune Avenue.	ral Home Baltimor	e, In	c. 2123	0
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	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. my	day		artu			1	Onset and	lines
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P.O.	thet tha deeth ce ed by the attend detached for us / Physician/	Part II. Other significant conditions Level Alm	entra of l	ly al	Sherres	type		Yes 2 No	_	pably 4□	
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ion	Attending or deeth. ector: After by the fune tification	1 Ø Naturel 5 ☐ Pending investigation		ar) Injun		ork?]Yes 2∐No					
Division	tal or Attending P rs effer deeth. al Director: Affer t led in by the funers Certification:	3 Suicide 6 Could not determined		At home, farm, pecify)	street, factory, office		28f. Location (: City or To	Street and Numb wn, State)	er or Rura	l Route Nur	nber,
	n 24 hour n 24 hour ne Funer pletely fill edical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of m miner: On the basis of exa and menner steted	y knowledge, de mination end/or	investigation, in my	opinion, death occu	, and due to the irred at the time,	date and place,	and due to	the cause(s)
	within Comp	29b. Signeture and title of certifier	3 Birche	is my	29c. Licen	LZ//Y		29d. Date signed	d (Month,	G Year)	
1	0	30. Name and address of person who	completed cause of death	(Item 23e) (Type RD - S	ve, Print) DN	S. BACK	BER BMCZE	CHESS MD,	and /d	29	
	State Registrar	31. Dete filed (Month, Dey, Yeer) MAY 1 5	32. Registrer's	Signature	porti						
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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [For State Registrar 1-Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MENDENHALL 1:58 / M 2006 MA 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 0 SP BAL If Under 1 Year HARBOR ENTER I MORE N/A 8. Date of Birth (Month, Day, Year) 12/13/1955 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1**⊠**M 2□F 215-70-7308 50 Yrs MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD N/A 1 ¥Yes 2 No Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1817 Jackson Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned white 1 Yes XX No Specify Specify à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Construction 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William L. Mendenhall Margaret E. Schilling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Neslein / Sister 105 Tacoma Street, Thurmont MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX Cremation 3 Removal from State Bayview Crematory 05/9/2006 Baltimore Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility . Charles L. Stevens Funeral Home, I 1501 E. Fort Avenue, Baltimore MD 21. Signature of Funeral Service Licenses Victor P. Doda, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRA 28 HOURS Due to (or as a consequence of): PER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 1 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ ¥0 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attanding Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or iteme 23a or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Physician /Medical

Examiner

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been

certificate

After this certifice funeral director, p

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIAOGUANG SUN HARBOR HOSPITAL CENTER 300/5 HANOVER STREET, BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year)

5 2006

32. Registrar's Signature

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medicai

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Marse 1955 Christopher Ja 12 2006 Harry 05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore City Hopkins Hospital The Johns 8. Date of Birth
(Month, Day, Year
It inc 6, 1951 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Months Hours 1**X**M 2□F 213-58-4762 54 Yrs. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exercises. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Frederick 1 ☐ Yes 2 🙀 No Virginia Winchester Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 256 Sawyer Lane 22602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M/No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical and plumbing Apprentice 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Christopher Marse, Sr. Mary Jean Sheppard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William W. Marse 11609 Cedar Lane Kingsville Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 5/16/06 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton 22 Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 mistua 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lymphoma Physician 2 months T-cell /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of): been signed by the attending physicien should be detached for use as the buria P.O. Box 68760 icai Physician/Med IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No 1 ☐ Yes 2 ☐ No certificate 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖪 Inpatient 1 ☐ Yes 2 ☑ No 3□ DOA P 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury at Work? Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No efter death. I Director: Af investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Hospital 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Couthornie Compaell MD May 12, 2006 Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine Campbell, The Johns Hopkins Hospital, God North Walfe Street Baltinume Maryland 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2006 Registrar

Please Type or Print in Black Indelible Ink

Konstantin Mitzev	1	- For State	e of Maryla	-	rtment o tificate o		nd Mental I		Reg No. 2 (006	1509			
Physiciai Medical Examin	n/	Registrar 1. Decedent's Name (First, Middle,L Konstantin Mitz						2. Date of De Month April 21,	ath		ime of Death 401 hrs			
	ľ	4a. Facility Name (if not institution, s 57 Strawhat Road	give street and nur	mber)		4b. City, Town, o			4c. County o		-			
Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Ye	ar If Under 24		irth (MM/DD/YYYY)		ce (State or			
Director	ļ		X M 2 F	5	52 Yrs	Months Da	ys Hours M	Min. Sept 1	4, 1953	Country	Bulgaria			
any	}	Usual Residence of Decedent 10a, State 10b. County		10c. City,	Town or Local	ion				10d.	Inside City Limits			
*	5	MD Baltim	ore Coun	ty	Owings						Yes 2 X No			
vith the Maryland s 23a or 28a-f show a e notified at once.	Director	10e. Street and Number				10f. Zip Code			10g Citizen of Wh					
with the		57 Strawhat Ros		edent Ever in U.				Specify Yes or N		- American Ir	ndian, Black,			
death or item	Funeral	1 X Never Married 2 Marr	1 Yes	2 X No	If Y	es, specify Cuba		rto Rican, etc.)	White	, etc.				
rs after ural", miner	à	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:		16a. Deceder	Yes 2 X N		of work done	Specify: 16b. Kind of Bus	white				
72 hou al Exa	ompleted	Elementary/Secondary (0-12)	College (1-			nost of working lif			Georg	ge Wil	liams			
DO36 within iene ner tha	교	12	none		Land S	urveyor	Lao sault - de Nie	/F:		ens & A	Assoc.			
다 중 수 로 됩	Be C	17. Father's Name (First, Middle, La	ist)			unk	18.Mother's Na	me (First, Middle,	Maiden Surname)		unk			
D 21 should to and Mer	힏	19a. Informant's Name/Relationship				,			imber, City or Town		Code)			
e, MD and 2 shoteleath and item 27 is		Thomas Stinnett 20a. Method of Disposition			Place of Dispo	sition (Name of c		Lethorpe Date	20c. Location -		n, State			
MOrd Pages I ent of I nut: If		1 Burial 2 Cremation 4 Donation 5 X Other Spec		Jili State	crematory or of	ner piace)								
Baltimore, permit Pages I a Department of He Important: If ite	1	21. tu or Funeral Serv. e Lin Ponald S	ensee Ware J	irector	c _ ²² S	Name and Addre	ss of Facility Bo	ard 655	W. Balti	more S	Street			
Physician	-	23a. art I. Enter the dis-se, and	mplic fons that ca	aused the death	. Do not enter	altimore the mode of dying	e, MD 21 g, such as cardia	201 c or respiratory a	rrest, shock, or hea	ırt Ap	proximate Interval			
/Medical / xaminer		f Nure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	a. Atheroscler			ease				Be	etween Onset and Death			
P.,		Sequentially list conditions,	ondition resulting in death) Due to (or as a consequence of): b. but to (or as a consequence of): Due to (or as a consequence of):											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c.	consequence o	of):									
uted nd ransit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a d.	consequence o	rf):									
(0, e be executed ysician and burial - transit	ledical	UNPENDED	AMENDED											
6876(certificate ading physe as the b	In/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	outcome of preg		etal death 3	Ectopic preg	gnancy	23d. Date of Month	delivery Day	Year			
Box 68766 he death certificate the attending phy hed for use as the b	Physician/M	1 Yes 2 No 9 Unkno		ant at time of de	eath 5 0	ther (Specify)								
O. Enat the d		Part II. Other significant condition			esulting in the	underlying cause	given in Part I.		tobacco use contril					
ords, P.O. w requires that th s been signed by should be detach	ed by							1 Ye	es 2 No 3		4 Unknown findings available			
of Vital Records, g Physician: The law require the the transference of the transferenc	Completed							auto	ppsy p		etion of cause of			
tal Reco		25. Was case referred to medical				26 Pla	ce of Death (Che	1 Yes	2 No 1	✓ Yes	2 No			
Vital hysician this cert	e Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatien		Othor	rsing Home 5	Residence 6	Other: Sce	ne			
ding Phy	\vdash	27. Manner of Death	28a. Date (Month	of Injury , Day, Year)	28b. Time of		jury at Work?	28d. Describe	how injury occurre	∍d				
Division ratendin rs after death.	catio	1 Natural 5 Pendin 2 Accident Investig	gation	E A			Yes 2 No	29f Leasting	(Chanat and Number	ar Dural D	auta Numbas Citu			
Divis	Certification:	3 Suicide 6 Could determ	not be		ome, rarm, sue	eet, factory, office	e building, etc.	or Town,	(Street and Numbe State)	i or Rurai Ro	oute Number, City			
동수 돌은		29a. Certifier (Check only 1 Certifying Phy			-				use(s) and manner e and place, and de		ıse(s)			
To the I within 2 To the I complet	Medical	29t Signature and title of certifier	and manner s				nse number		29d. Date signe					
		lloubre The	Kull			0.0	C.M.E.		April 22, 20	06				
		30. Name and address of pirson w Margarita Korell MD.	ho completed caus Assistant Med	,		Penn Street,	Baltimore, M	D 21201		-12				
Sta Regist	ate rar	31 Date filed (Month, Day Year)	2006 32 Re	egistrar's Signat	A April	des								

			1 - State of Maryland / Dep	artment of Health and N rtificate of Death	lental Hygier	7006 10091
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		Marie Agnes McCartan		May 8, 20	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Death
			Anne Arundel Medical Center	Annapolis		Anne Arundel
г	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director		522-42-6210 78		May 15, 1	927 Ireland
	land ow		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary 1 sh	ţ	Maryland Anne Arundel C	denton		X Yes 2 No
	1 the	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a o		493 Greenwood Street	21113		United States
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
ဖွ	after or Ite	F	1 Never Married 2 Married 1 Yes 2 Tho	1 ☐ Yes X☐ No Specify:	rrican, etc.)	Black, White, etc.
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "neturel", or Iteme 23a or 28e-f show event, the Modical Examinat must be notified at	d by	3 Widowed 4 Divorced Year or Dates:	TE 103 PE 110 Openly.		White
2	72 h	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation o kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Industry
2121	within noe. then	m	Elementary/Secondary (0-12) College (1-4or 5+)			Dants
N	filed v Hygie other I		2yr Den 17. Father's Name (First, Middle, Last)	tal Assistant	e (First, Middle, Maid	Dentistry
aryland		Be c	John C. Cooke		gette	Troy
2	2 should be in and Mental I is marked or raumatic eve	ဥ		ing Address (Street and Number or Rur		
<u>8</u>	d 2			Greenwood Street		Maryland 21113
<u>ق</u>	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		20a Method of Disposition 20b. Place of Disp			Location - City or Town, State
e E	Pages nent of I ont: If Its ury or o		1 M Burial 2 U Cremation 3 U Hemoval from State	Veterans Ceme 5/15	5/2006 C	rownsville, MD
altimore,	그 문문을 .			2. Name and Address of Facility onaldson Funeral I		
m	Department Department Important Impo		Juanta Chomos 1	411 Annapolis Road	d Odenton	Maryland 21113
	100		23a. Palt 1 Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician:	s 19	Immediate Cause (Final disease or condition		r	Onset and Death
	/Medical		resulting in death) a Due to (or as L consequence of):			
	Examiner	. 1	Sequentially list conditions.			
7	Sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Colleges of think of the cause of think of the cause of think of the cause of think of the cause of think of the cause of the caus			
00	and and I-trans	Examiner	that initiated events resulting in death) Last			
760,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	a E	230 to (or 20 2 001,000,001,000 01),			
687	icate phys s the	dical	d			
Box (leath certifica attending ph	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
ă	death a atter	iclar	in the past 12 months? 1 Ves 2 XNo 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
о <u>.</u>	that the death cer ed by the attendin detached for use	Physiclan/Me	9 Unknown		- Permission	
	w requires that been signed k should be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underfying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ğ	an sig	ed	Crohn's Disease Early (rrhoses	1 🗆 Yes	2 No 3 Probably 4 ⊠Unknown
Records,	aw re	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	The law ate has bage 2:	mo;			performed 1 ☐ Yes 2 🗹	? death?
Vital	iclen: Th certificate rector, pag	a	25. Was case referred to medical	26. Place of Deat	h (Check only one)	
>	nysic lis ce direc	To B	examiner? 1 ☐ Yes 2 🖔 No Hospital: 1 ☐ Inpatient 2 🖔 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residence	6 ☐ Other (Specify)
0	Attending Physiclen: or death. ector: After this certifice by the funeral director, p		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how in	njury occurred
20	death. ctor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
Division of	l or Attencater death Director:	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	pital ours a erel [O	29a, Certifier 1/7 Certifying Physicien: To the best of my knowledge, dea	th assumed at the time date and place	and due to the source	(a) and manner or stated
	To the Hospital or Attending Physiclen: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1D Certifying Physicien: To the best of my knowledge, dea (2 ☐ Medicel Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	o thin o the	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
	->=0		> Keith & awstre, or	D57019	m	1 ay 8, 2006
	CK		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		
	8		Keith Damsker, MD 1390	1 Solomons/slo	and Road	1 Annapolis, no 21401
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1		
	Registr	ar	MAY 1 5 2006 Been &	park)		

	-	1- For State of Maryland / Department of He Registrar Certificate of D	Death	Reg. I	- Z. U U D	15092
Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month MAY 1	Oay Year 4, 2006	3. Time of Death
/Medic	al -	Rosina Pecora 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or life the content of the cont	Location of Death		4c. County of Death	=:30 H"
Examin	er	Saint Joseph Medical Center	Towson		Balti	
Funeral Director		5. Social Security Number 214-38-6360 6. Sex 1 M 2X F 7. Age (In yrs. last birthday) 72 Yrs. The security Number 1 Year Months Days	If Under 24 Hrs. 8. [Hours Min. (Date of Birth 6- Month, Day, Yea	9. Birthr 006	lace (State or Foreign atry) Italy
land ow	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
a-feh	tor	MD Baltimore Parkville				1 ☐ Yes 2 ☐ XNo
ath with the 23a or 28 ust be nat	rai Director	106. Street and Number 10f. Zip Code 21234			Citizen of What Cour	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: if Item 27 is marked other then "natural", or Itame 23s or 28s-1 show any injury or other treumatic event, the Madical Examinar must be notified at once.	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 No Year or Dates:	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
72 ho	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupal (Give kind of work done di	uring most of working	16b.	. Kind of Business/In	dustry
within within then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Hair Dresser			Beautici	an
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mantal Hygiene. It is marked other then "natural", or treumatic event, the Mudical Exam	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fil	rst, Middle, Maid Fico	len Sumame)	
Mary nd 2 shou aith and M 27 is mar	-	19a. Informant's Name/Relationship (Type, Print) Albert E. Pecora (brother) 9330 Ravenrid				
Ore, es 1 a of Hea filtern r othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Date		Location - City or To	own, State
liment ment tant: fi		4 Donation 5 Sther (Specify) Entombment Dulaney Valley Me			Timonium,	
Baltimore, permit. Pages 1 ar Department of Heal Important: if Item any injury or othe		Stephen Coster 1050 York	s of Facility Ruck k Road, Tow	son, Ma		-
Burnish	ì	23a. Part1. Enter the disease, or complibations that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.		spiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) METASTATIC ENDOMETRIAL. Due to (or as a consequence of):	CHNCEK			
LAAHIIITEI	e	Sequentially list conditions ff any, leading to immediate cause. Enter Underlying				
acuted Ind Iransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			_	
18760, Cate be executed physician and the burial-transit	dical Ex	Due to (or as a consequence of): d.				
Records, P.O. Box 68 The law requires that the death certifica tite has been signed by the attending ph bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown	- vila vila		23d. Date ol delive Month	ery Day Year
, P.(y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
cords, P w requires that s been signed t should be deti	ed by			1 🗆 Yes	2. No 3 ☐ Prot	oably 4 Unknown
Vital Records, sician: The law requires to certificate has been signs rector, page 2 should be.	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	? prior to co	psy lindings available mpletion of cause of
vision of Vita Attending Physician: r death. ector: After this cartific by the funeral director,	Be	25. Was case referred to medical examiner?	26. Place of Death (C)			
Phys Prithis aral dii	7: To	123 179 220 123 179 179 179 179 179 179 179 179 179 179	at 28d.	5 Residence Describe how in	6 □Other (Special fluory occurred	^(y)
anding anding ath. or: Afte	atio	1	í? ∕es 2 □No			
# # # # # E	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)	28f.	Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
Hospital 124 hours a Funeral I	edical (e, date and place, and pinion, death occurred a	due to the cause at the time, date	e(s) and manner as s and place, and due t	taled. o the cause(s)
To the within 2 To the complet	Me	29b. Signature and time of certifier 29c. License	number	29d.	Date signed (Month,	
			254		5-14-0	6
6		30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	TOUCON N	IABVI AN	ന്ന തിടത്തും	
Sta	ite	21 Date filed (Month Day Year) 32 Registrar's Signature	TOWSON, M	IPHX T L. PHI	ID 21204	
Regist	ar	MAY 1 5 2006 Seem & Aprile				
DHMH 17 Rev 1/2	001	ORIGINAL				

			For	State of Maryla				Mental Hy	gien/	e 200	6 15093
			State Ragistrar			Certificate of	Death		Reg. N	o	0 10050
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month		ay Yea	3. Time of Death
	/Medic			ilalbhai	Pat			MAY	-	1 200	
	Examin	er	4a. Facility Name (If not institution, give		3		r Location of Death			c. County of D	
			BALTIMORE WASHING 5. Social Security Number 6. Se	TON EDICAL	ENTE		U BURNI If Under 24 Hrs.	€ 3. Date of Bi		14	RUNDEL Birthplace (State or Foreign
	Funeral Director			м 2 Д F 82		rs. Months Days	Hours Min.	July 2	av Yea	1923	Country) India
			Usual Residence of Decedent					July 2	,	1725	India
	nylan how		10a. State 10b. County	10c. C	City, Town	or Location					10d. Inside City Limits
	ath with the Marylan 23s or 28e-f show	Director	Maryland Anne A	runde1		Hanover			_		1 ☐ Yes 2 No
	ith th	- Si	10e. Street and Number			10f. Zip Code			10g. C	itizen of What	Country?
	death with the Maryland me 23a or 28e-f ehow russi be ticiliad at		1400 Palmetto Dr				076			Britain	
CO	ar de teme	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No	U.S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No p Rican, etc.)	D-	14. Race - A Black, W	merican Indian, hite, etc.
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 24∑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify: A	sian-Indian
DEN 5-003	within 72 hours after dea ane. then "naturel", or tteme to Medical Examination				16a	Decedent's Usual Occur	ation		16h	Kind of Busine	
		Completed	15. Decedent's Edu (Specify only highest grad		-	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of world)	king	100.	Tana or basino	33 madsay
A W₁	d with	E	5th	College (1-4or 5+)		Homemaker				Own H	ome
m W	be filed withintal Hygiene. Ind other then event, the M	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	, Maide	n Sumame)	
<u> a</u>	should be and Mental te marked o	ToE	Bacherbhai	Pate1			Suraj	ben	Pa	atel	
/ の Maryl	2 sho and I te ma	1	19a. Informant's Name/Relationship (T)	rpe, Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Numb	er, City	or Town, State	e, Zip Code)
	and ealth n 27		Vibhakar Patel/son			00 Palmetto	Drive	Hanover	_		
Q. ore	000-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		Place of cemetery	Disposition (Name of crematory or other place	(e)	Date	20c. I	Location - City	or Town, State
Ë	Pag tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)	Wes	st Aı	undel Crema					Maryland
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens			22. Name and Addre Donaldson 1411 Annar	ss of Facility Funeral colis Roa	Home & d Oden	Cre	matory, MD 21	P.A. 113
			23a. Part 1 Enter the disease, or composhock, or heart failure. List only o	ications that caused the dea	ath. Do n						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pullman	15.	Mars de	land				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quenee	0:	wite -				
	LAGITITIE	_	Sequentially list conditions, if any, leading to immediate	MydCal	dis	y Jutar	Cotron				
V	ed ssit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to foras a conse	equence o	- 1					
٧.	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a conse	equence o	all me					
68760,	ficate be executed physicien and is the burial-transit		l	_							
687	ficate physicate	edicai									
Box	eath certif attending for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr		o∏5				23d. Date of	delivery
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 🕱 No	1 Live birth 2 Fet 4 Pregnant at time of		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				Month	Day Year
P.0	at the by th	hys	9 Unknown	9□ Unknown							
Ś	Physician: The law requires that the death certi this certificate has been signed by the attending ral director, page 2 should be detached for use a	by F	Part If. Other significant conditions co.	ntributing to death but not re	sulting in	the underlying cause give	en in Part I.	23e. Did 1	obacco	use contribute	to the cause of death?
ord	pluot	ted	421mma	,				10	Yes 2	5 (X (N° 3 □	Probably 4 Unknown
e	law lasb	nple	Hypertension	Μ				24a. Was	psy	24b. Were	autopsy findings available o completion of cause of
=	The law cate has page 2 s	Completed	Diabetos	Mollitus				perfo 1 ☐ Yes	2 N	death	?
Vita	lysician: Th	Be	25. Was case referred to medical examiner?	lospital:			26. Place of Dea	th (Check only	one)		
ot	Phys this al dir	۲:	1 Yes 2 No	28a, Date of friery	ER/Out		4 Nuising n	ome 5 Resi			pecify)
Division of Vital Records,	S 55	tion	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)		ury Wor	yat k? Yes 2 □ No	28d. Describe	now infi	ury occurred	
is:	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At I	home, fari			28f. Location (Street a	and Number or	Rural Route Number,
Θ	affor a	Certification:	4 Homicide determined	building, etc. (Spec	cify)			City or To	wn, Sta	te)	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin	nowledge,	death occurred at the tin	ne, date and place, pinion, death occur	and due to the	cause(s) and manner	as stated.
	thin 2 the l	Medical	29b. Signature and little of centrier	and manner stated.	-	29c. License					nth, Day, Year)
	⊢ ≱ ∺ ŏ		/ de la n	11 / 4 4	X	1	w cola i	OI	. /	١	ith no
	-1.		30. Name indiadd iss person who co	ompleted cause of death (Ite	om 23a) (1	vpe. Print)	05771	(10	ard	X006
	7		Julius & Ala	am 301	Has	sited in	Glen	Restrain	1	UN	21061
	Sta		31. Date filed (Month, Day, Year)	32. Ragistrar's Sign	nature			-J-4-(1C)	-	- 1/	
	Registr	ar	MAY 1 5 20	106 Messue	J.	Spark					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Frank Poole 2:00P M May 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 6 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 15√M 2□ F 89 219-01-7101 Vrs Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Mudical Examiner must be notified at Maryland Anne Arundel Annapolis XXYes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Garden Gate Lane or Items 23a 21403 USA fited within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Black þ Specify: 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Depertment of Health and Mental Hygien Important: If Item 27 ie marked other than any injury or other traumatic event, Insuce. 6th 0 Army Air Force Exchange U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Poole Sarah Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Powell(Daughter) 988 Generals Highway Crownsville, Md. 21032 20b. Place of Disposition (Name of Bengery Grantatery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 5-8-06 Annapolis, Md. 21. Signature of Funeral Service Licensee M000482 Wm. Reese & Sons Mortuary, P.A. Tarry ee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Buckerial **Physician** senris /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of). .O. Box 68760, Completed by Physician/Medical the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EN/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑No 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury death. 1 Yes 2 No 2 Accident investigation To the Funeral Director: completely filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L Techtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of centile 29d. Date signed (Month, Day, Year) D3+03 C who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 1), Dont Ore Clarke, M.S use LIUP 31. Date liled (Month, Day, Year) 32. Paristrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

		-	_ State	State of Man	•	epartment Certificate		nd Mental Hy	4000	15095
			1. Decedent's Name (First, Middle, Last)			Certificate	OI Death	2. Date of De	Reg. No.	3. Time of Death
	Physicia /Medic	an	MARY ETTA	ROHRB	AUGH	4		Month	Day Year 09 200	6 3:40 PM
	Examin		4a. Facility Name (If not institution, give str				own, or Location of		4c. County of De	ath
			SINAI HOSPITAL				TIMORE			
	Funeral Director		5. Social Security Number 6. Sex 181-03-2283	7. Age (i	In yrs. last birti	hday) If Under 1 Months		Min (Month Da	th ly, Year) 9. B 25, 1919 MA	irthplace (State or Foreign Country)
4		į	Usual Residence of Decedent							
	yland		10a. State 10b. County	1	0c. City, Town					10d. Inside City Limits
11	Mar-1s	ctor	MO		BALT	IMORE	CITY			1 Mres 2 □ No
. 7	th the	lre	10e. Street and Number	_		10f. Zip C	Code		10g. Citizen of What 0	Country?
2	death with the Maryland ms 23a or 28a-f show r roust be notified at	a [155 GRUNDY S	STREET			11224		USA	
B	ems er	Funeral Director	11. Marital Status	2. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decede If Yes, specif	nt of Hispanic Origi y Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - An Black, Wh	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet must be notified at ance.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 Yes 2	No Specify:		Specify:	WHITE
$\mathcal{M}_{\mathcal{R}}$ And $\mathcal{E}_{\mathcal{H}}$ Maryland 21215-0036	2 hou	ted	15. Decedent's Educa		16a.	Decedent's Usual	Occupation done during most	of working	16b. Kind of Busines	s/Industry
215	thin 7	Completed	(Specify only highest grade	College (1-4or 5+)		life. DO NOT use	retired)	or working	11 1 ==	
2 2	ed wi	S				LOMEMA		de Norma (Circh & Goddle	HOME	
8AU 6H	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)					's Name (First, Middle HIE AL		
\$ \$ 5	noutd f Men narke	은	ISAAC JENNI 19a. Informant's Name/Relationship (Typo		105	Mailing Address			er, City or Town, State	Zin Code)
OHR	12 st hand 7 is n		_					BALDWIA		1013
()	1 and Healt em 2	1	LARRY RUHRBAU (20a. Method of Disposition	<i>></i> H	20b. Place of	Disposition (Name	e of	Date	20c. Location - City	or Town, State
→ Jou	ages int of t: If it y or o		1	moval from State	Cemeter	y, crematory or oth AwN (E)	HETERY M	AU Pach	BACTINGR	F MD
$\mathcal{R}_{\mathcal{A}}$ Baltimore.	nit. Partme oortan injur		21. Signature of Funeral Service Licenses		,	22. Name and	Address of Facility	JOSEPH N. Z	ANNING, JR	F. H.
å	permii Depar Impor any ir		I WUW	. Jenne	nd	263 S.	CONKLIN	6 57. BA	LTIMORE,	MD 21224
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the	ne death. Do r	not enter the mode	of dying, such as c	cardiac or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Acut	e Re	ral Fa	ilure			Chisel and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):				
		-	Sequentially list conditions, if any, leading to immediate	Due to for as a	consequence of	of):				
[red nsit	III	Cause. Enter Underlying Cause (Disease or injury	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
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8760	cate be executed physician and the burial-transit	dical	d.							
g	ntifica ng ph	Med	IF FEMALE:							
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0	that the death ed by the atte detached for	by Physician/Me	1 □ Yes 2 ⊠ No 9 □ Unknown	4☐ Pregnant at tir 9☐ Unknown	ne or death	5 Other (spe	спу)			
	that th	/ Ph	Part II. Dther significant conditions cont	ributing to death but	not resulting in	the underlying ca	use given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
of Vital Becords	quires t							1 🗆	Yes 2□No 3□	Probably 4 Unknown
Ş	s been si should	Completed						24a. Was	an 24b. Were	autopsy findings available o completion of cause of
A d	The lav te has	E O						auto	ormed? death	?
ā	ysician: The is certificate hidirector, page	a)	25. Was case referred to medical				26. Place	of Death (Check only		
>	nysici nis ce direc	To B	examiner? 1 Yes 2 No	spital: 1 🔀 Inpatient	2 ER/Ou	tpatient 3 DO	Other: 4 Nur	sing Home 5 🗆 Res	idence 6 □Other (S)	pecify)
	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. 1		c. Injury at Work?		how injury occurred	
. <u>.</u>	ttendii death. ctor: A y the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 Yes 2 N		(6)	Dumi Dauta Mumbas
Division	or Attend after death Director:	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At nome, ta (Specify)	.m, street, factory,	опісе		(Street and Number or iwn, State)	nural noble Number,
	urs urs ille								cause(s) and manner	
	To the Hosi within 24 ho To the Fund completely f	edical	one)	er: On the basis of e and manner state	examination and.	d/or investigation,	in my opinion, deati	n occurred at the time,	, date and place, and d	
	To t To t	Σ	29b. Signature and little of certifier	mD		290.	License number	70	29d. Date signed (Mo	nin, Day, Year)
	1		11/11			1	100031	70	11/10/109	1200
	φ		30. Name and address of person who cor	npleted cause of dea	ath (Item 23a) (Wesi	(Type, Print) + Belve	due Ave	70 2. Baltin	nove, MD	21215
	St. Regist	ate	31. Date filed (Month, Pay Year) MAY 1 5 20	32. Resistrar	's Signature	South	,			
	negisi	ıaı	_ 0	1						

			For State Registrar	State of Marylan		rtment of H			C 0 0 0	15096
			Registrar Decedent's Name (First, Middle, Last)			inoute or i	Doutin	2. Date of Death	. No.	3. Time of Death
ı	Physicia		Sophia T	Tann	R	ceffing		Month	Day Year	2 45 FM
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	Location of Death	7	4c. County of Dea	
		•	The Johns Hopki	ins Hospita	el	Balt	imore C	Lity	None	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bi	rthplace (State or Foreign country)
	Director		205 70 0917 1 Usual Residence of Decedent	M 200 F 1	Yrs.		- 22	March 16	, 2005	Maryland
	land bw		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary fied	to	MD Howard		Woo	dstock				1 ☐ Yes 2√2 No
	r 28e	irec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	th wit	aiD	10353 Cavey Lane			2116	3		USA	
	ems	ne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	or It	by Funeral Director	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █No If Yes, Give	1	☐ Yes 2 XNo	Specify:		Specify: A	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Exdustroust be notified at	ed b	15. Decedent's Edu	Year or Dates:	16a. Deced	ent's Usual Occup	ation	16	b. Kind of Business	s/Industry
75	in 72 n "na Audic	Completed	(Specify only highest grade	completed)	(Give	kind of work done OO NOT use retired	during most of worl	king		2
212	d with jiene. ir tha	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)		N/A			N/A	
b	al Hys	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)	
yla	Ment Ment arked atic e	10	Russell Charles F	Ruffing			Donna Je			
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (Ty	•				ral Route Number, C	City or Town, State,	Zip Code)
e, P	1 and 1 ealth am 27 ther t		Russell Ruffing/fa		10353	Cavey L	ane Woo	CONTRACTOR OF THE PARTY.	D 21163 c. Location - City o	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ite Mudical Examitive from the notified at one.		1 ☐ Burial 2 XCremation 3 ☐ R	emoval from State		natory or other place	⁽²⁾ 5/15		Catonsvil	
턮	artmer ortant injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License				1 '			mily FH Inc.
Ba	Department of the service of the ser		Vouri L. K	Ada MO14			olumbia I		cott City	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat	h. Do not ente	er the mode of dyin	ng, such as cerdiac	or respiratory arrest	t,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	1				
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68760	icate be executed physician and s the burial-transit	dicai		J						
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Вох	death certifii e attending p id for use as	an/h	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of de Month	Day Year
O.	υ ψ ω	Physician/M	1 Yes 2 No	4☐Pregnant at time of d 9☐Unknown	leath 5□	Other (specify)			A Contain	Day / Jul
Δ.	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
ds,	signed d be de	d by	Anthe coarcta	tion		, ,		1 ☐ Yes	2010 3 □ P	robably 4 Unknown
Record	w requii been s should	Completed	Atial spotal d	o but				24a. Was an	24b. Were a	utopsy findings available
Re	0 5 0	duc	Minar Septar d	1 1 1 +				autopsy performe	gt? death?	completion of cause of s 20 No
Vital	ician: Th certificate ector, pag	a)	25. Was case referred to medical	Tal affect			26. Place of Dea	1 ☐ Yes 2/2 th (Check only one)	No 1 ☐ Ye	5 25 110
Ţ	S S	To B	examiner?	fospital: Impatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5 Residence	ce 6 □Other (Spe	ecify)
n of	ng Ph fter thi neral		27. Manner of Death 1 ØNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how	injury occurred	
Sio	Attending F or death. actor: After I by the funera	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 ☐ No			
Division	or A ifter Dirac	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre fy)	eet, factory, office		City or Town, S		iural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Diraci completely filled in by	edicai C	(Check only 2 Medicel Exemi	sicien: To the best of my kno ner: On the basis of examina						
	To the l within 2. To the I complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29d	. Date signed (Mon	th, Day, Year)
	F. 2 E. 8) me	M	MO	RES	5-000		May 11.	2006
			30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type,	Print)	7			
			Megan McCabe	MO GOO	ON, i	Nolfe S	H. Bal	timore,	MD a	1287
:	Sta		31. Date filed (Month, Day, Year)	MO (CX)	ature Joseph	e i				
	Registr	ar	MAY 1 5 2006	Maria P	1					

Please Type or Print in Black Indelible Ink of Maryland / Department of Health and Mental Hydie

Anita E. Richards		1- For State	tate of Maryla		partment of certificate of		and N	Mental H			21	006	1509
Physicia		Registrar 1. Decedent's Name (First, Midd	lle,Last)						2. Date of De	Reg. No eath		3	Time of Death
Medical Examir		Anita E. Ric							Month April 30,	2006	Year		1013 hrs
		4a. Facility Name (if not institution					n, or Loc	ation of Death			c. County of		
-		Baltimore /Washingto				Severn					Anne Aru		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Months	_	f Under 24Hrs Hours Min	⊣	•	1	Enreign	ace (State or
Birector		216-60-9837	1_M 2XF		52 Yrs		,		Feb	5 1	954	Countr	y) D.C.
any		Usual Residence of Decedent 10a State 10b County		10c. C	ity, Town or Locat	ion		_				10	d. Inside City Limits
*	_1	Maryland Anne	Arundel	.	Severn								Yes 2X No
aryiai	Director	10e. Street and Number				10f Zip Co	de			10g. Cit	izen of Wha	t Country	?
vith the Maryland 23a or 28a-f show s notified at once.	ä	1311 Somerse	t Rd.			21	144			1	USA		
with ms 23	eral	11. Marital Status	A	edent Ever in					pecify Yes or N	lo-			Indian, Black,
death	Funeral		larried Armed Fo	2 X No		es, specify C	uban, Me	exican, Puerto	Rican, etc.)		White,	etc.	
s after ral",	by	THE RESERVE THE PARTY OF THE PA	vorced If Yes, Give Yea or Dates:		1	Yes 2X						Blac	
hour "natu	ted	15. Decedent's Education (Spe Elementary/Secondary (0-12)						(Give kind of v NOT use reti		16b.	Kınd of Busi	ness/Indu	stry
136 hin 72 e than	ple	12th	2yr	,	Comr	niter	Pro	grame	r	l _F ,	edera	1 G	overnmen
5-00 ed wit ygien other	Completed	17. Father's Name (First, Middle			1 00111	Juoci			(First, Middle				- CITIMEN
215 be file ntal H rked o	Be	William D. D	orsey				E	Edith	Conwa	У	·		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene "item 27 is marked other than "natural", or items 23a or 28a-f sho r traunnatic event, the Medical Examiner must be notified at once	ပ	19a Informant's Name/Relations							Rural Route No				
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Baltimore, MD 21215-0036 semit Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", njury or other traumatic event, the Medical Examiner		1 X Burial 2 Cremation	n 3 Removal fr	om State	b. Place of Dispos	ition (Name o perplace)	of cemete	ery,	Date		Location - C	•	
imch Pag ment tant: or ot		4 Donation 5 Other S			Bethel			- 1	6-06		dento	-	1C.
Baltimore permit Pages 1 a Department of He Important: If it		21. Signature of Funeral Service			22.N Wr	n. Re	dress of F	& Son	s Mor	tua	ry, P	.A.	
Physician	-	Zavry H. Re 23a. Part I. Enter the disease, or	complications that c	83 aused the dea	1.83	1 We	at. 9	St. An	napol	is.	Md.	2140	
/Medical		failure. List only one cause	on each line				y 11 19 1 Octob	. 1 40 04 4140 0	respiratory a	11031, 311	ock, of fleat		Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		_W	d	. !!									
0, e be ex	edical	X UNPENDED	AMENDED	item#23	a,PII,27,pe	erME,g85	6,6/8	3/06 TT					
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x 6 th cert th cert truse a	Physician/M	past 12 months?	4 Pregn	ant at time of	death	ner (S <i>pecify)</i>	, []r	ctopic pregna	ПСУ	ļ	Month	Day	Year
Box te death of the atten	hys	1 Yes 2 No 9 V Un	9 Unkno			reparted to							
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Rec The I	悥								1 V Yes	ormed?		ath? Yes	2 No
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Division of Vital Records, tal or Attending Physician: The law requirers after death. The Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director.	Ë	1 X Natural 5 Pen		, Day,Year)	28b. Time of I	· ·	Injury at	2 No	28d. Describe	how inj	ury occurred		
IVISIOR or Attend after death Director:	icat	2 Accident Inve	stigation 28e Place	e of Injury - A	t home, farm, stree				28f Location	(Street :	and Number	or Burol F	Route Number, City
Division Spital or Attent hours after death uneral Director:	Certification:		Id not be (Specify)	- c,a., ,		A, radiony, on	ioo banan	rig, cic.	or Town,		ind Number	oi Ruiai r	toute Number, City
the Hospita hin 24 hours the Funeral		20a Cartifica	hysician: To the bes	at of my knowl	edge, death occur	red at the tim	e. date a	nd place, and	due to the cau	ise(s) ar	nd manner a	s started	
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Exa	miner:On the basis o	of examination	n and/or investigat	ion, in my op	inion, dea	ath occurred a	t the time, date	and pla	ace, and due	to the ca	use(s)
F 3 F 3	ž	29b. Signature and title of certific				29c. Li	cense nu	mber		29d.	Date signed	(Month,	Day, Year)
	J	ull	22			0	.C.M.E	<u>.</u>		Mag	y 1, 2006		
(0)	1	30 Name and address of person				· · · · · · · · · · · · · · · · · · ·		ND C.CC					
		Ana Rubio MD. As:		=xaminer gistrar's Sign	111 Penn S	treet, Ball	imore,	MD 21201					
Sta Registi		MAY 1		gistial's Sign	H. And	ales							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene / For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** SCOPE OSCAR 1159 PM March 16,2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Days Hours Yrs. 578-34-5976 78 March 22,1927 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County al Hygiene. other then "natural", or iteme 23a or 28a-f ehow went, the Medical Examiner must be notified at Yes 2□No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 3000 MCComac Avenue United States Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) XXYes 2 11/26/45-If Yes, Give 122/25/45-1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 02/25/47 1 ☐ Yes 2 ☐ No Specify: Specify: Black Š 3 ☐ Widowed 4 NDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Payroll Clerk Twelve One Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil tment of Health and Mental H tent: if Item 27 is marked ott jury or other treumatic even Oscar Scope Sr Susie Lewis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i Nikki Scope-Harris/Daughter 607-Hamilton St NW, Washington DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State March 24, 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if eny injury or once. Quantico National 4 ☐ Donation 5 ☐ Other (Specify) 2006 Triangle, Virginia 21. Signature Ineral Service 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope Rd SE Wash DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebra disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine or Attending Physicien: The law requires thet the deeth certificate be executed efter death.

Director: After this certificate has been signed by the ettending physicien and use as the burial-transit Due to (or as a consequence of) resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes → No 24a. Was an 1□ Yes 2 DNo After this certifical funeral director, a 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 Who 1 Inpatient 2 X P/Outpatient 3 DOA Division of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending efter death. Director: Aft 1 TYes 2 No investigation the the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours of To the Funeral D completely filled in Hospital 29s Conflian t 💢 Contifying Physiciam. To the best of my knowledge, death occurred at the time, date and plane, and dire to the naissa(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) å 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3120106 500, MD DO057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Billytr Spring Hospital LIUSS 31. Date filed Month, Day, Year) 32 Registrar's Signature 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amends item#4c.perivD.855,5/16/06 TT

			For Stata Registrar	"State of Mai	-	artment of F ertificate of		ental Hygie	2000	15099
	Physicia		1. Decedent's Name (First, Middle, Last) Leonard Schilz					2. Date of Death Month 5/6/06	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give 694 Charingworth	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dear	
	Funeral Director		5. Social Security Number 6. Sept 390-54-4263	x 7.Age TMM 2□F	(In yrs. last birthda) 55 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birt ear) Co	hplace (State or Foreign buntry) WT
	and w		Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town or	Location				10d. Inside City Limits
	Maryi I-f sho	tor	MD Ca	rroll		West	minster			1 □Yes 2□No
	with the	Director	10e. Street and Number 694 Charingworth	Court		10f. Zip Code	21158	10g	. Citizen of What Co	
	ns 23	Funerai	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13	. Was Decedent of I	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
920	be filed within 72 hours after death with the Maryland Hygiene. dother than "netural", or items 23e or 28e-f show dother than "netural", or items 23e or 28e-f show event, the Modical Exam and must be rivilled at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 22010 If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 20X No		Hican, etc.)	Black, Whit	white
21215-0036	netura	Completed	15. Decedent's Edu (Specify only highest grad		(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of works	ng 16	b. Kind of Business	/Industry
2121	filed within Hygiene. Sther than ent, the Me.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Vice Presi	•		Auto Pari	ts
	al Hygi d other	Be C	17. Father's Name (First, Middle, Last)	Cobile	,		18. Mother's Name	(First, Middle, Ma		
Maryland	should be filed nd Mental Hygi marked other umetic event, I	P	Leonard Aloysius		10b Ma	iling Address /Street	RUTH G	eraldine	~	Zin Code)
	nd 2 s lith ar 27 is r treu		Patricia A. Schil				ngworth Co		*	
altimore,	90 = 3		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)		St. Ada.	ematory or other pla Lbert Ceme	etery Un	_	c. Location - City or Milwaukee	
Baltii	permit. Pag Department Important: eny injury once.		21. Signature of Funeral Service Licens		oda	22. Name and Addres L.	ess of Facility Stevens Ort Avenue	Funeral H		
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused to	he death. Do not e					Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	L	ver fo	riture				Onset and Death
	/Medical pe executed fitted pe executed fitted and physician and strength fitted fitte	cai Examiner	Sequentially list conditions, I any, I add go to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): a static consequence of): consequence of):	colpre	ectal co	U CL		Zyears
O. Box 68	ie death certiff the attending hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	□Ectopic pregnanc □ Other (specify)	у		23d. Date of de Month	livery Day Year
σ.	uires that the signed by Id be detac	by	Part II. Other significant conditions co.	ntributing to death but	t not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	S 2	o the cause of death?
Records,	The law require ate has been single page 2 should b	Completed						24a. Was an autopsy performe	24b. Were at prior to death?	utopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Deat	(Check only one)	¥140 123 133	
of	ys dis	မ	1 Yes 2 No 27. Manner of Death Natural 5 Pending	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time	of 28c. Inju	ry at	me 5 Residence 28d. escribe how	ce 6 Other (Spe injury occurred	cify)
Division	f or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	ry - At home, farm, (Specify)	M 1 street, factory, office	Yes 2 No	28f. Location (Stre City or Town,	et and Number or R. State)	ural Route Number,
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	To the within 2 To the complex	Me	29b. Signature and title of certifier	1/		29c. Licen	11 .0	290	. Date signed (Mont	h. Day, Year)
)	0		· Vaul Cr	lang, &		DI	6597		May 8,	2008
l) "		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Typ	e, Print)	Triva	on MD	21204	
	Sta Registi		31. Date filed (Month, Pay Year) MAY 1 5 2	006 32. R strai	r's Signature	Spark	7 1000	0 -1 0 0	-inc/	

			1 - For State Registrar		State of	f Maryland		artment rtificate			nd Men		ene) (06	15100
	*		1. Decedent's Name (First, Mic	die, Last)								Date of Death	Day	Year	3. Time of Death
	Physici /Medic		Diane Louise	Sawye	r							May 9	2006		11:50 P ^M
9	Examin		4a. Facility Name (If not institut	ion, give str	eet and nun	nber)		4b. City, To	wn, or Lo	cation of I	Death		4c. Cour	nty of Deat	th
			Stella Maris						Tows						imore
	Funeral Director		5. Social Security Number 218–44–5095	6. Sex	4 2 X F	7. Age (In yrs. la 59	ast birthday) Yrs.	If Under 1 Months		Under 24 Hours		Date of Birth Month, Day, 1. 17	1946	9. Birt Co M a	thplace (State or Foreign try) aryland
	and and		Usual Residence of Decedent 10a. State 10b. Cour	ty		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl fehc	0	MD	N/A				Balti	more						1 X Yes 2 □ No
	28a	rect	10e. Street and Number					10f. Zip C	ode			10	og. Citizen o	of What Co	ountry?
	3a or	0	2026 Grinnald	s Ave	nue				212	230			Unit	ed St	tates
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show or other traumatic event, fire Medical Examinatement is incitified at	by Funeral Director	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	arried	. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	2 ANO	- 1	Was Decede		anic Origir Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- n, etc.)		lack, White	orican Indian, e, etc. nite
2	72 ho	sted	15. Deced (Specify only hig.	ent's Educa	tion		16a. Dece	dent's Usual kind of work	Occupatio	n ina most o	of working	-	6b. Kind of	Business/	Industry
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Maryland	12 sh and rie m		19a. Informant's Name/Relatio									ute Number,			,
_	1 and Health em 27 ther tr		Ellen Perry – 20a. Method of Disposition	Sist	er	20h PI	ZUZ6 ace of Dispo			Aven	ue, B	altimo			Z30 Town, State
Baltimore,	F F F F	,	1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	noval from S	State C6	idon Pa	natory or oth	er place) netei	-	-12-2	006 E	Baltím	ore,	MD
Ball	permit. Departn Imports eny inju	(21. Signatural Samural amura S	V Contract		19 lb	VIIV					e Fune , Lans			
	Pnysician /Medical		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complication on by one	LUNG	aused the death ach line. CANCER or as a consequ		er the mode	of dying, s	such as ca	ardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
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V	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.	Due to (or as a consequ	uence of):								
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	w requires that been signed b should be deta	þ	Part II. Other significant cond	itions contr	ibuting to de	eath but not resu	ilting in the u	nderlying cau	se given i	in Part I.			acco use co s 2 □ No		the cause of death?
Division of Vital Records,	The law rate has be page 2 sh	Completed							·		_	24a. Was ar autopsy perform 1 Yes 2	/	prior to death?	utopsy findings available completion of cause of 2 No
ita	Physician: this certificanal director, i	Be	25. Was case referred to medi examiner?	-					1	6. Place o	f Death (C)	neck only one			
<u>></u>	hysiv his co I dire	5	1 ☐ Yes 🛣 No	Ho			ER/Outpatier					5 🗆 Reside			city) HOSPICE
ion c		Certification:		stigation	28a. Date of (Mont	of Injury th, Day Year)	28b. Time o Injury	f 28	. Injury at Work? 1 ☐ Yes	s 2□No		Describe ho	w injury occ	urred	
N N	al or Att	Sertific	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide deta	ld not be rmined	28e. Place buildir	of Injury - At ho ng, etc. (Specify	me, farm, str	reet, factory,	office		28f.	Location (Str City or Town	eet and Nur , State)	nber or Au	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	Medical (29a. Certifier (Check only one) Certifier (Check only one)	ying Physic al Examine	cian: To the or: On the ba and mann	best of my know asis of examinat ner stated.	wledge, deat ion and/or in	h occurred at vestigation, i	the time, my opini	date and ion, death	place, and occurred a	due to the ca t the time, da	use(s) and te and plac	manner as e, and due	stated. to the cause(s)
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	2		30. Name and address of pers						D .	TT-40-	MTID4	MD 014			
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DHMH 17 Rev 1/2001

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MAY 9, 2006

DIANE SAWYER

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month :95A Physician Elsa Schapmeier 100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. 23, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex Year) 909 **Funeral** 1 ☐ M 2 🛱 F 96 Maryland 216-01-0435 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State or 28a-f show traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 1 No Maryland Baltimore Catonsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21228 16 Fusting Ave. or items 23a Completed by Funeral filed within 72 hours efter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2 XNo White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. I other than " College (1-4or 5+) Elementary/Secondary (0-12) unknown Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If Itam 27 is marked other any injury or other traumet: 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Appler unknown (First name unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lloyd Smith - friend 818 Francis Ave. Arbutus, MD. 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition West Arundel Crematory 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 5-14-2006 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Cause (Disease of inju-that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? fo 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2 No certificate the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner's Other: Hospital: 1 ☐ Yes 2 💢 No Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 his 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No death. **Diractor**: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and little of certifier of death (Item 23a) (Type, Print) 00 Oc State Registrar

			For State Registrar	State of M	aryland /	-	artment of H tificate of L		d Mental Hy	giene Reg. No.	006	15102
	Physici	3.7°	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month		Year	3. Time of Death
	Physici /Medic		Jacob Stolzen	oach					MAY	Day	2006	9:00 PM
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or BALT 11		eath (4c. C	County of Death	
	A.F. marrel		Social Security Number 6. S		e (In yrs. last t	oirthday)	If Under 1 Year	If Under 24 F	Irs. 8. Date of Bir	th	9. Birthol	ace (State or Foreign
1.	Funeral Director		219-86-4758	X M 2□ F	29	Yrs.	Months Days	Hours M	lin. Sept. 23	ıy, Year) 1976	6 Mary	ace (State or Foreign try) 1and
	p ,		Usual Residence of Decedent 10a. State 10b. County									
	aryla ehov	ъ	Maryland Howard	1	10c. City, To						10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Funeral Director	10e. Street and Number		ETE	krid	ge 10f. Zip Code			10g Citize	en of What Coun	
	with 3a or	ī	6514 Vert Drive				,					uy:
	death me 2	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Vas Decedent of Hi	075 ispanic Origin?	(Specify Yes or No		USA 4. Race - America	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23s or 28s-f show other traumatic event, Ire Madical Examiner must be nutified at	by	1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:			f Yes, specify Cuba I ☐ Yes 2 ☑ No	Specify:	ierto Hican, etc.)	S	Black, White, e	White
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	ia. Deced	lent's Usual Occupa	ation during most of	workina	16b. Kind	d of Business/Ind	ustry
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12	filed w Hygie other ti		17. Father's Name (First, Middle, Last)	2			Superv		Name (First, Middle,		chinery	
ano	ould be i Mental I Mrked o	o Be		1 - 1 - 7						, 1412/00(10	umamoy	
Ž	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, Irs M.	T ₀	Nicholas J. Stolz 19a. Informant's Name/Relationship			9b. Mailin	g Address (Street a		Kunsman Rural Route Numb	er, City or	Town, State, Zip	Code)
	alth a		Paula Stolzenbach	Mother	6	514	Vert Dri	ve: Elk	ridge, MI	2107	75	
ore,	of He of He fitem r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domayal from State	20b. Place	of Dispo	sition (Name of natory or other plac	θ)	Date		ation · City or Tov	wn, State
im	nit. Page vartment o ortant: If injury or ©.	П	4 Donation 5 Other (Specify		Lake		w Mem. Pa				ville, M	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra once.		21. Signature of Funeral Service Licer	Telm	ester	7 F	Name and Address uneral Ho 30 Edmond	s of FacilityStome of Ason Av	terling As Catonsvil enue; Cat	shton le, I	Schwab Inc.	Witzke
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each li	the death. Do	o not ente	er the mode of dyin	g, such as card	fiac or respiratory a	rrest,		Approximate Interval Between
	Physician	į,	Immediate Cause (Final disease or condition	. MET	A STAT	16	CANCEL	2				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):	CANCE!					
	LAUTHICI	١	Eaquentially list conditions,	D	a consequence		4COMA					
11	nsit fe	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (oi as	a consequence	a oij.						
4	sician and burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as	a consequence	e of):						
68760,	ificate be executed g physician and as the burial-transit	edicai	(d								
	rtificate t ng physi as the b		IF FEMALE:									
Вох	eath certif attending for use a	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal dea	th 3 □	Ectopic pregnancy			23	d. Date of deliver	
0.	at the dea by the all tached fo	Physician/M	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5 🗆	Other (specify)				MONTH	Day Year
0	that the ed by detac		Part II. Other significant conditions c	ontributing to death b	ut not resulting	in the ur	nderlying cause give	en in Part I.	23e, Did to	obacco use	e contribute to the	e cause of death?
of Vital Records,	S C G	d by	NONE						1 🗆 '		,	ably 4 Unknown
00	tw require s been sig should b	Completed							24a. Was	an	24b. Were autop	sy findings available
Re	: The law cate has page 2:	Шo						· · · · · · · · ·	autor perfo	rmed?	prior to com death?	pletion of cause of
ita		BeC	25. Was case referred to medical					26. Place of D	Death (Check only o		1 105	2 140
) \(\)	\$.∞ 5	To	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ERVO	Outpatien	t 3□ DOA Cthe	or: 4 🗆 Nursin	g Home 5 ☐ Resid	dence 6	Other (Specify,)
	ing Ph	on:	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	28c. Injury Work		28d. Describe	now injury	occurred	
Sio	ttend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be		At hama	6		Yes 2 □ No	006 1 (24	M	
Division	ul or Attending Patter death. Director: After the in by the tunera	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	rarm, stre	eet, factory, office		City or Tov	vn, State)	Number or Rural	Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowled	ge, death	occurred at the tim	ie, date and pla	ace, and due to the	cause(s) ai	nd manner as sta	ated.
	n 24 }	edical	(Check only 2 Medical Exam	iner: On the basis o and manner st	f examination a	and/or inv	restigation, in my op	oinion, death o	ocurred at the time,	date and p	lace, and due to	the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier	M	N		29c. License	-			signed (Month, D	
	L.		Jahranv -	, , , , , ,	シ		RES				4,9,2	-006
	13		30. Name and address of person who		leath (Item 23a) (Type,	Print) 56	altimi	och Paire	n P	128	
*	Sta		31. Date filed (Month, Day, Year)		ar's Signature	100	ness					
	Registr	ar	MAY 1 5 20	US Farmer	S. S. S.	0	1000					

DHMH 17 Rev 1/2001

STOLZEN BACH, J'AROB

		•	For State Registrar	State	of Marylan	•	artmer <i>tificat</i>			nd Me		giene Reg. No.	2006	15	103
			Decedent's Name (First, Middle,	Last)						2	. Date of Dea	ath Day	Year	3. Time of	Death
	Physicia		Hilda	Μ.		Soulsb;	у			M	lay 13	, ,	2006	5:00	Ам
1	/Medic Examin		4a. Fecility Name (If not institution,	give street and n	ımber)		4b. City,		Location of I			4c.	County of Death		
			4801 Arabia /	\venue					timore				N/A		
	Funeral Director		5. Social Security Number 212-12-5807	6. Sex 1 ☐ M 2 X) F	7. Age (In yrs.	last birthday) 93 Yrs.	If Unde Months	1 Year Days	If Under 24 Hours	Min.	Date of Birt Month, Da June 2	5, 1	9. Birth Cou Ma	ryland	or Foreign
	pu 🔭		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	ity Limits
	•ho	ō		/A		•	imor	<u> </u>						1X Yes	2 🗆 No
	286-1	Directo	10e. Street and Number	<i>,</i> , , , , , , , , , , , , , , , , , ,		Dare	10f. Zi					10g. Citi	izen of What Cou	untry?	
	3a or		4801 Arabia	Avenue					21214				U.S.A.		
	me 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.	Was Dece	dent of Hi	spanic Origin	n? (Speci	fy Yes or No can, etc.)	-	14. Race - Amer Black, White		
ယ္	filed within 72 hours elter deeth with the Maryland Hygiene. the then 'natural', or iteme 23a or 28e-f ehow ent, it a Madical Eabyliner must be notified at	Fu	1 ☐ Never Married 2 ☐ Marri		2 💢 No		1 🗆 Yes		Specify:		ouri, 0.0.,		Specific		
93	iours irai'.	d by	3 X Widowed 4 □ Divorced	Year or	Dates:							101 10	wn	ite	
5	"nati	Completed	15. Decedent (Specify only highes	s Education grade completed	")	16a. Dece (Give	dent's Usu kind of wo DO NOT i	rk done d	luring most o	of working	,	16b. Ki	ind of Business/l	naustry	
12	withir ene. then	dmo	Elementary/Secondary (0-12)	College	(1-4or 5+)		ne Ma						Own Hom	e	
<u>0</u>	Hygi Other	Be C	17. Father's Name (First, Middle, I	ast)					18. Mother's	s Name (First, Middle.	Maiden	Sumame)		
a	Mental Mental rked ric ev	To B	Will (Unkno	wn)					Is	abe1	Lamb				
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours effer deeth with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28e-f show say injury or other traumatic event, it a Middles Examination at an other 200.		19a. Informant's Name/Relationsh				•					_	r Town, State, Z		
Σ.	end 2 eelth m 27		Joseph Urban -	Nephew:	205 5	-	-		Avenu	e B			MD 2121 ocation - City or 1		
Baltimore,	ges 1 t of H if ite		20a. Method of Disposition 1 Disposition 1 Cremation		n State	Place of Dispo cemetery, crei	natory or	other plac					•		
Ë	t. Pa rtmen rtant: njury		4 Donation 5 Other (S)			Lawn			s of Facility		/2006 5305		timore, ford Ro		and
Ba	Depariment of the part of the		21. Signature i Puneta Service i	TCG112GG CTTQT	163 111116				-				e, MD 2		
			23a. Part1. Enter the disease or	complications that	caused the deat									Approximat	10
	Physician		shock, of heart failure. List	only one cause on	each line.	i a								Onset and	
j	/Medical		disease or condition resulting in death)	aDue to	o (or as a consec	quence of):									
	Examiner		Sequentially list conditions.	o en	estas	e ver	ral.	dise	ase						
	D =	ner	frank, leading to immediate cause. Enter Underlying Cause (Disease or injury	Suan	o (or as a consec	uence of):									
	ecute and trans	Examiner	that initiated events resulting in death) Last	c.	o (or as a consec	uience of):									
8760,	icate be executed physicien and s the burial-transit	a E			(0. 20 2 00000	,00,000									
687	ficate p phys is the	edicai		d											
Вох	deeth certific e attending p d for use as l	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregn	ancy	⊒Ectopic į	vogn on ou					23d. Date of deli		
m.		icia	in the past 12 months?		gnant at time of o		Other (s						Month	Day	Year
<u>о</u> .	thet the de ned by the a detached	Physician/Med	9 Unknown	<u> </u>		ü				-	02- Did		use contribute to	the series of	doosh2
	8 5 5	Ď	Part II. Other significant condition	ns contributing to	death but not res	sulting in the L	inderiying	cause give	en in Parti.			Yes 2			Unknown
oro	w requir been si should	eted	Laranema	L'y UT	cas						-				
3ec	e law hes t	Completed								—	24a. Was		prior to death?	topsy findings completion of c	cause of
a	ician: The certificete herector, page	င္ပ	25. Was case referred to medical						OC Bloom	of Dooth	1 ☐ Yes Check only	2 No	1 ☐ Yes	2□ No	
₹	Physician: rthis certific ral director,	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3 🗆 🖸	OA Oth					6 □Other (Spec	cifv)	
10			27. Manner of Death	28a. Dai	e of Injury onth, Day Year)	28b. Time o		28c. Injun Wor	y at	28	8d. Describe	how inju	ry occurred	**	
Ö	Attending r death. ector: After by the fune	atlo	t Watural 5 Pendin 2 Accident investig	pation	, , , , , , , , , , , , , , , , , , , ,	(2.)	М		Yes 2 □ N	О					
Division of Vital Records,	or Attendated of the control of the	ertification:	3 Suicide 6 Could a determination	inad 288. Pla	ce of Injury - At h Iding, etc. <i>(Speci</i>	iome, farm, st	reet, facto	ry, office		28	If. Location (City or To		nd Number or Ru 9)	iral Route Nun	n <i>ber</i> ,
Q	pitel c	O	200 Coddier 450 Codd	g Physician: To t	he heet of t	owlodes de-	h a	1 01 15 - 1	no doto and	place	ad dua to the	001105/-) and manage	hateta	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical		Examinar: On the											s)
	To the	Me	29b. Signature and title of certifie					c. Licens					ite signed (Monti		
			Frank S. S	almiran	Frank	5		DOS	9475	7		0.	5-12-0.	6	
	37		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type	, Print)	- 2 11			2. !	7.4	A. 4. 67	4 5	12111
			FRANK S. PA. 31. Date filed (Month, Day, Year)	MISAN	Registrar's Sign	MID.	5%	INH	AS(10)	PD &	D. 1	21/	MOILE !	VID: X	WIY,
	St: Regist	ate rar		5 2006	A CASAS .	13° 19									

			1 - For State Registrar	State of	Marylai		artment of l tificate of		d Mental Hy	giene Reg. No.	306	15104
	H		1. Decedent's Name (First, Middle, Las	1)					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medic		Virginia Frances Sc	hollian					May 12,	2006	rear	3:10 P. M
	Examin		4e. Fecility Name (If not institution, give	street and num	ber)		4b. City, Town,	or Location of De	eath	4c. Co	unty of Death	
			Ma Maison Assisted Liv				Perry		lan Landau		timore	
	Funeral Director		5. Social Security Number 6. Se 215-09-9475	9X □M 2□XF	7. Age (In yrs 94	. last birthday) Yrs.	If Under 1 Year Months Days		tin. 8. Date of B (Month, D	irth lay, Year) 1911	9. Birth Cou Mary	place (State or Foreign Intry) Tand
	p >		Usual Residence of Decedent 10a. State 10b. County		100.0	ity, Town or Lo	antion					10d. Inside City Limits
	shov	'n	Maryland N/A			ltimore	Cation					1 XYes 2 No
	the N 28a-f	ect	10e. Street and Number				10f. Zip Code			10g Citizen	of What Cou	
	with Ba or		3408 Pinewood Avenue				212	206		USA	or writer coo	inity's
	death	era	11. Marital Status	12. Was Dece	dent Ever in l	J.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or N	0- 14.	Race - Ameri	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐ Yes If Yes, Give	2. /∆N o ∋		f Yes, specify Cut 1 □ Yes 2 No		uerto Rican, etc.)		Black, White, ec <i>ify:</i> Whit	•
21215-0036	hour turai	q pe	3 Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Da	tes:	16a Decer	dent's Usual Occu	nation		16h Kind	of Business/Ir	aduates
5	in 72 na na	ojet	(Specify only highest gra	de completed)		(Give	kind of work done	during most of	working	TOD. KING) Dusinessyn	loustry
2	with liene r than	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		tchboard (Retail		
	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)					18. Mother's I	Nam <i>e (First, Middl</i>	e, Maiden Sui	mame)	
Maryland	Ments Ments	To E	Joseph Mitchell					Ida Kell	ler			
an	2 sho and I is me		19a. Informant's Name/Relationship (7	•					Rural Route Num		wn, State, Zi	p Code)
	and lealth m 27		William F. Schollian,	Jr./Step			Pinewood /	Avenue Ba	altimore Ma	,	21206	
50	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from S	itate	cemetery, crer	natory or other pla		Date		ion - City or T	
Baltimore,	t. Pa rtmen rtant: njury		'4 □Donation '5 □ Other (Specify				rvice Corp		15/06	Towson	Marylan	d .
Ba	permi Depar impor any ir		21. Signature of Funeral Service Licen	See Christ	ina L. 1	Hilton 2	Name and Addr copard J. 305 Hartor	Ruck Inc	Båltimore M	aryland	21214	
68760,	/Medical Examiner bhysician and streep fransit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a conse	quence of).	ne CO	BRANG	L Urie	уа	wa	1e
P.O. Box 68	The law requires that the death certifica tte has been signed by the attending phoage 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		nth 2∏Fet ant at time of	al death 3	Ectopic pregnand Other (specify)	у		23d.	Date of deliv	rery Day Year
S,	es that gned b	by Pr	Part II. Other significant conditions of	ontributing to de	ath but not re	sulting in the u	nderlying cause g	ven in Part I.				the cause of death?
ord	w require been sign	ted							_ 1	Yes 2 N	lo 3 🗌 Proi	bably 4 Unknown
Division of Vital Records,	The law ite has boage 2 st	Completed							24a. Wa auto perl 1 ☐ Yes	s an 2- opsy ormed? 22 No	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
Ita	slcian: The certificate i	Be C	25. Was case referred to medical examiner?						Death (Check only			- A 26+ C7 EA
× ×	hysic his ce Il dire	일	1 ☐ Yes 2 2 No			ER/Outpatier	I 3L DOA		g Home 5 □ Res	idence X	Other (Special	W L/V/Ng
Ĕ	ing P	ion:	27. Manner of Death 12 Natural 5 ☐ Pending		f Injury n, <i>Day Year)</i>	28b. Time of Injury	Wo		28d. Describe	how injury or	curred	0
visio	Attend r death sctor: A	Certification:	∑ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place	of Injury - At I	home, farm, str	M 1 [Yes 2□No			umber or Rur	al Route Number,
	taforrs afteraiDire	Cert	4 [] Homicide	buildin	g, etc. (Spec)			City or Te	own, State)		
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier Check only one) Certifying Ph	ysicien: To the niner: On the ba and mann	sis of examin	nowledge, death nation and/or in	n occurred at the tweetigation, in my	ime, date and pl opinion, death o	ace, and due to the ccurred at the time	cause(s) and date and pla	manner as s ce, and due t	stated. o the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of certifier	/			29c. Licen	se number		29d. Date si	gned (Month,	Dey, Year)
	-1-0		I Man Ken	ulul	NI	>	D	2102		5/	15/0	6
	10		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print) 7/	12 R	Inio &	1 R	go to	MD 21236
	- Ct-	•	MARION C. 31. Date filed (Month, Day, Year)		gistrar's Sign		1 16	ve pe	- wir k	u, p		" वार्याक्ष
	Sta Registr		MAY 1 5 2	006	9-10 D	B 3	garde)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** April 29, 2006 23:19 p M Charles Simonson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1⊠M 2□F unk unk Director 42 Jan 1, 1964 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene.
Important: if item 27 is marked other than "neturel," or iteme 23a or 28e-f ehow any injury or other treumatic event, the Madical Examination and be notified at once. 10a State 10b. County 1 Yes 2 No Director Prince Georges Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unk 3807 Swann Rd. #302 20746 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Unemployed unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Rd. Clinton, MD 20735 Southern Maryland Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 21. Si mature of Funeral Service Lil ensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ronal Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine EOho the attending physicien and the for use as the burial-tran Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed: The 2X No 1 Yes Vital Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xinpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA After this ŏ 27. Manner of Peath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Attending Division 1X Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier D0061652 MD

Registrar

State

MAY 1 5 2006 DHMH 17 Rev 1/2001

ATUL KATYAL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9131

. Registrar's Signature

PISCATAWAY

fo, SUITE-750,

CLINTON

Please Type or Print in Black Indelible Ink

William David Senger, III State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death Medical Examiner William David Senger, III April 18, 2006 1556 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 104 W. Clay Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6 Sex unk Months Davs Hours Foreign Director $_{1}\mathbf{X}_{M}$ Country) 2 F Oct 31, 1957 48 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any items 23a or 28a-f show ust be notified at once. 1 X Yes 2 No MD Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country unk 104 W. Clay Street 21201 Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, unk Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk White, etc. Never Married Yes If Yes, Give Year Specify: white Widowed 4 Divorced Yes 2 X No specify: than "natural", þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 hent of Health and Mental Hygieneant: If item 27 is marked other than "nor other traumatic event, the Medical E unk unk unk unk 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) unk unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M 0.C.M.E. 111 Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other in 21 Signature of Emperal Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Ronald tor Baltimore, MD 21201 Physician Enter the disease, or com caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval List only one cause on each line Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Wuse (Final disease [™]xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical r use as the bir UNPENDED AMENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed l 2 should be deta ð 1 Yes 2 No 3 ✓ Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending Yes 2 No the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. **Medical** within 2 To the I 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Lo and manner stated 29b. Signature and title of certified 29c, License numbe 29d. Date signed (Month, Day, Year) OCME April 19, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Year) gistrar's Signatu State Registra

DHMH 1/ Ray 1/2001 **OCME 2006**

ORIGINAL

		State of Mary State Amend Item 29d per Dr.	and / Depa , G855 ,05	artment of He	ealth and M Death	ental Hygie	ene . No.2 11 11 6	15107
	14	Decedent's Name (First, Middle, Last)				2. Date of Death	- 12	3. Time of Death
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the M 28a-f	Director	MD 10e, Street and Number	Baltimore	10f. Zip Code		100	. Citizen of What Cou	intry?
with Be or	ā	4828 Park Heights Avenue		21215		1.09		
heath	Funeral	11 Marital Status 12. Was Decedent Ever	in U.S. 13.	Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Amer	ican Indian,
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Saltimore, bernit. Pages 1 ar bepartment of Heal mportant: if Item my Injury or other Mice.		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☒ Other (Specify) in state						
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VISION Of VItal Records, P.O. Box 6 Attending Physician: The law requires that the death certificeable. releath. ector: After this certificete has been signed by the attending by the tuneral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Day Year
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Vital Ficials: The certificate	Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		
D Of V g Physic er this ce eral dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatie		4 Nursing no	me 5 Residence 28d. Describe how	ce 6 □Other (Specinjury occurred	fy)
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Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat mination and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th within To th	Me	29b. Signature and title of certifier		29c. License	number	29d	I. Date signed (Month	Day, Year)
		PHYSICIAN		25	7543	M	lay 12, 200)6
3		30. Name and address of person who completed cause of death P. J. A. P. H. V. M. 1940 31. Date filed (Month, Day, Year) 32. Registrar's S. MAY 1 5 2006	(Item 23a) (Type,	Print) -i TIMORE	ST BA	LTIMORE	modi	223
St. Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	, , ,			, , , , , , , , , , , , , , , , , , , ,	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 4 **Physician** Ronald. L. Shreve 0219 M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 8005 Crest Road Laurel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1KIM 2□ F Yrs. Virginia 577-52-3484 67 09-06-1938 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road Grest U.S.A. 8005 20723 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 NYes 2 No If Yes, Give Year or Dates: 1956-1959 within 72 hours efter 1 ☐ Never Married 2 🗓 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Grocery permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy,
Important: If Item 27 is marker
eny Injury or other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boradus Gilbert Shreve Lillian Virginia Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8005 Crest Road Laurel MAryland 20723 Judy Shreve, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 5/8/2006 Falls Church, VA 21. Signature of Foge al Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Lymphocytic Leukemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, loaning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 √ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 No Division of Vital 1 Yes 2 No Hospital or Attending Physician: Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours af To the Funeret D completely filled i Cartifying Physician: To the bast of my knowledge ideath occurred at the time, date and place; and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29s Cartifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) cheet D0055522 May 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Gerard, MD 1500 Forest Glen Road Silver Spring MD 20910 32. Registra s Signature 31. Date filed (Month, Day, Year) State MAY 1 5 2006 Margare . Registrar

			State of Marylan State of Marylan Registrar		artment rtificate				F	Reg. No.	006	15109
	Physicia	an	Decedent's Name (First, Middle, Last) BENJAMIN	A2	1ALL				2. Date of Dea MAY 11		6 Year	3. Time of Death 5:05 P M
	/Medic Examin	Share and	4a. Facility Name (If not institution, give street and number) AUGSBURG LUTHERAN HOME		4b. City, To		BALT	IMORE			unty of Death BAI	TIMORE
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	th with	ai D	3707 VILLA NOVA ROAD				21207					USA
036	within 72 hours after death with the Meryland ene. then "nstural", or Itama 23a or 28a-f show the Medical Exertifier Lant Le notified a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes, Give Year or Dates:		Was Decede If Yes, specif		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		Race - Ameri Black, White, pecify:	
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760,	y a M	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen									
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.O. Box	Physician: The law requires that the death certificate be executed trins certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[⊒Ectopic pre ⊒ Other (spe					230	d. Date of deliv Month	ery Day Year
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	ths Hospital	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my king the physicien on the basis of examinant manner stated.									
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(Ì		30, Name and address of person who completed cause of death (It	em 23a) (Type		^		EIR	7/75/	AVE	BAI	RIMI
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Sig		0 /	1114	_ //	αq	ו בעת	110	O	21208
₩.,	Regist	rar	MAY 1 5 2006 Region .	B. As	Me		_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1215 P LAURA THOMAS MAY 8 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WORTHWEST HOSPITAL RAMOALLS TOWN BALTIMO RE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 1 F Yrs. Usual Residence of Decedent 10b. County 10c. City Town or Location 10a State 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 1200 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1□Yes X No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Givelkind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tome makei 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be tone 0 Informant's Name/Relationship Kesville 20b. Place of Disposition (Name of cemetery, crematory or other p Date athod of Disposition Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days disease or condition resulting in death) Due to (or as a Insequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen of): Examiner Dreimones Due to for as a consequence of) Medical Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Hnknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

The law requires that the deeth certificate be executed use as the burial-transit attending physician for Division of Vital Records, P.O. the detached signed by pe page 2 should this certificate has completely filled in by the funeral director, Director: After or Attending within 24 hours e To the Funerel I

Funeral

Director

other treumatic event, the Medical Examiner must be notified at

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end Mental Hygiene. Is marked other than

should be

Pages 1 and 2 s nent of Heelth en Depertment of Heelth e importent: if item 27 is any injury or other tre once.

Physician

/Medical

Examiner

the Maryland

72 hours after death with or iteme 23a or

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 50059736 pso 8 2006

State Registrar

To the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MCLT AM

COURT RUND 5401 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** allor tha 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs. Min. 7. Age (In yrs. 5. Social Security Number 6. Sex ast birthday 9. Birthplace Country) **Funeral** Days Year) 1□M 2 F 214-22-819 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No 40 Director Da timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21215 USA 238 HVZ 1032M1+2 Funeral Heme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after c and Mental Hygiene. Le marked other then "natural", or Item 1 ☐ Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNK vate Duty Nurse IVar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be nent of Health and Mental rank 104415 ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 a Department of Health ar Important: If Item 27 Ie eny Injury or other trau once. Yosemite Ave Baltimore Taylor Daughter inethia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Randallstown 115/06 4 ☐ Donation 5 ☐ Other (Specify) Memoria Rock Com, 21. Signature neral Serv icensee - Harris 22. Name and Address of Facility Chatman Funcial Home areres 5240 heisterstown Ad Baltimore 14d x1215 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or he in failure. List only one cause on each line. Part1 Approximate Interval Between Onset and Death Immunate Cause (Final dinase or condition resulting in death) **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine anding physiclen and use as the burial-transit The law requires that the death certificate be executed OK Zar Due to (or as a consequence of) P.O. Box 68760, ettending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown cate hes been signed, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 2 No certificate 1 ☐ Yes Division of Vital the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 20 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Dertifying Physician: To the best of my knowledge death occurred at the time, date and alone, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the hwithin 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Beagtra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

5 2006

Records, P.O. Box 68760, CATHERINE WILMOT of Vital Division

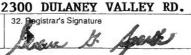
> State Registrar

DHMH 17 Rev 1/2001

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29a, Certifier

Medical

29c. License number

3

TIMONIUM, MD 21093

29d. Date signed (Month, Dey, Year)

106

			Please Type of Frint III Black Indelible Ink. Ensure Al	-	
			State of Maryland / Department of Health and M	ientai Hygie	ⁿ 2006 5 3
			1 - Stete Registrar Certificate of Death	Reg.	
	Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Yeer 3. Time of Death
1	/Medic		Emily Wagner	MAY 1	Z 2006 D AM
	Examin	er	4a. Facility Name (If not institution, give strebt and number) 4b. City, Town, or Location of Death		4c. County of Death
				more	None
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 M 2 DXF 7 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		354 18 8832	Sept 27,	1913 Canada
	land ow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
>	Mary fed	Ď	MD Howard Ellicott City		1 ☐ Yes 2 📆 No
3	ith the Marylar or 28a-f show	Jec.	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
3	death with the Maryland ms 23a or 28a-f show	Funeral Director	10001 Gallahad Court 21042	τ	nited States
H	death ms 2	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi		14. Race - American Indian,
ຸ	after or Ite	₫	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Sive 1 ☐ Yes 2 ☑ No Specify:	rican, etc.)	Black, White, etc.
33	hours after tural', or te	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:		Specify: White
2.6	4 within 72 hours after death with the Maryla jiene. Trhan "natural", or Items 23a or 28a-1 show Ite Madical Examina in ust be invitited at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ing 16	b. Kind of Business/Industry
\(\frac{2}{2}\)	within 72 ene. than "nai	mp	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		
2	lled v tygie her t		10 Accounts Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name	Un e (First, Middle, Mai	iversity of Illinois
\ a	h be f ntail h ed oi	Be	Michael Maruda Clara Hu		our carraine,
$\mathcal{U} \cap \mathcal{E} \mathcal{N} \in \mathcal{L}$ Maryland 21215-0036	12 should be filed within and Mental Hygiene. 7 Is marked other than raumatic event, It w.M.	ပ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		ity or Town State Zin Code)
<u></u>	s 1 and 2 should be filed if Health and Mental Hyg item 27 Ia marked othe other traumatic event,		Claire Meitl/Daughter 10001 Gallahad Court E		and the same of th
نَهِ	1 an Heal Heal		20a Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or Town, State
Baltimore.	ages int of t: If if		1 □ Burial 2 □ Cremation 3 🗷 Removal from State 1 □ Donation 5 □ Other (Specify) Mary Hill Cemetery 5-17	-2006	Nilos II
<u> </u>	artme ortan injur			The state of the s	Niles, IL zke's Family FH Inc.
B	permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra		Jun Coli- White 4112 Old Columbia P		
	- 4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final		Onset and Death
	/Medical		disease or condition resulting in death) a		yeurs
	Examiner		I anorexia		months
	Mary and the	ner	Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that mitiated events conditions).		
H	cuter nd trans	Examiner	Cause (Disease or injury that initiated events c.		
, 0	be executed ician and burial-transi		resulting in death) Last Due to (or as a consequence of):		
8760	ate b hysic the b	lical	d		
Box 68	entific ling p	Physician/Medi	IF FEMALE:		
Bo	ath c	lan	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery Month Day Year
0	the a	ysic	in the past 12 months? 1		
۵	that the od by detact		Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Division of Vital Becords.	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	d by	Hypertension	1 🗌 Yes	2 No 3 Probably 4 Unknown
Ö	v requ	Completed	Huno Hauroidium	24a. Was an	24b. Were autopsy findings available
e B	2 5 8	mp	(1) 10 (VI VI 01 00 3 7 VI)	autopsy performa	prior to completion of cause of death?
70	n: Tł ficate or, pa		25. Was case referred to medical 26. Place of Deatl	1 Yes 2	No 1 Yes 2 No
<u> </u>	alcia cert irect	o Be	examiner?	h (Check only one)	e 6 □Other (Specify)
o,	Phy Pr this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	
no	rth. :: Afte	tion	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		
<u></u>	Atter r dea ector by th	Hice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
اغ	s afte	Certification:	4 Homicide building, etc. (Specify)	Only of Town, C	1210)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr	and due to the caus	e(s) and manner as stated. and place, and due to the cause(s)
	the H hin 24 the F nplete	Medical	one) and manner stated.		
	To To	4	29b. Signature and title of certifier 29c. License number 1) (-(-2)	$Q_1 \mid_{\Lambda}^{290}$	Date signed (Month, Day, Year)
	^			1 IV	lay 12, 2006
	3		30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming V, 3320 IS-enson / venue, ISaltima	re M.	aryland 21227
	Sta	ite	31. Date filed Month Day, Year) 32. Registrar's Signature		7
	Regist		MAY 1 5 2006		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

900 CATON AV BALTIMORE

3. Time of Death

DHMH 17 Rev 1/2001

10

State

Registrar

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

ST. AGNES

32. Registrar's Signature

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MISHARMA

31. Date filed (Month, Day, Year)

MAY 1 5 2006

	For	State of Maryland / Department of Health and Mental	Hygiel
 -	For State Registrar	Certificate of Death	Rag. I

		1 = State Registrar	Ce	rtificate of	Death	Rag	g. No.	
		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
Physi /Med		Symanthia R. Allen				04/25/		3:55 a ^M
Exam		4a. Facility Name (If not institution, give street and number	oer)	4b. City, Town, o	or Location of Death		4c. County of Death	
		Washington Adventist		Takoma			Montgome	
Funera		104 W75	Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/24/	Year) 9. Birth	olace (State or Foreign ntry) 110
Directo	r	Usual Residence of Decedent				04/24/	1722 01	110
/land		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
Mary	ţ	DC	Washing	ton				1 ☑ Yes 2 ☐ No
r 28s	irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
th wit	a D	1429 Montello Ave. NE		20002		1	U.S.A.	
dea	Funeral Director	11. Marital Status 12. Was Deced	ent Ever in U.S. 13. es?	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
or it		1 Never Married 2 Married 1 Yes 2	⊠No	1 ☐ Yes 2 ☐ No		, ,		ack
Hours Pours	d by	3 Widowed 4 Divorced Year or Dat						
n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of works	ing	6b. Kind of Business/Ir	ndustry
within the n	E P	Elementary/Secondary (0·12) College (1-4	lor 5+)	estic	0,	(Governmen	t
Hygi Hygi	ပိ	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	aiden Sumame)	
id be fill ental Hy ked oth	To Be	Harvey Burnes			Helen A	Agee		
shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street			City or Town, State, Zij	o Code)
Man nd 2 st aith and 27 te n r traun		Michael A. Allen/ Son	1712	M.Stre	et NE Wa	shingto	on,DC 200	02
S 1 a		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other pla	ce) i	Date 2	0c. Location - City or T	own, State
Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)			CEM. 05	5-02-06	TRIANGL	E, VA.
DESILITIOFE, INITIVITIES AND A LET 13-0030 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Iteme 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be notified at		21. Signature of Funeral Service Licensee	1	2. Name and Addre	kof Fagiliyd I	aylor 3	II Funera	1 Chapel
0 8855	3	Halent Unllean	2,1 1	0583 Mi	ddleport	Ln.Wh:	ite Plain	s,MD
		23a. Part1. Enter the disease, or complications that cal shock, or heart failure. List only one cause on each	used the death. Do not en ch line.	ter the mode of dyir	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition	enepro	1/A CCAL	las a	(Cide	nt	Onset and Death
/Medica Examine		resulting in death) Due to (o	r as a consequence of):	000	10 /			
LAdillile		Sequentially list conditions, b.						
ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequence of):					
xecut and	xan	that initiated events c. Due to (o	as a consequence of):					
w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit								
oo / filicate g phy:	Medical	d						
or cert	1	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes	ome of pregnancy	4 // 2000			23d. Date of deliv	ery
Geatte	Icla		nt at time of death 5	□Ectopic pregnancy □ Other (specify) _	у		Month	Day Year
requires that the death or signed by the attenct hould be detached for us	Physician	9 LJ Unknown						
es the	b	Part II. Other significant conditions contributing to dea	th but not resulting in the u	underlying cause giv	ven in Part I.		acco use contribute to I	1
requires been sign	Completed					1 L Yes	2 □ No 3 □ Pro	bably 4 Unknown
1	nple					24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
VII INC. sicion: The law certificate has b	Co					perform 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	20 No
VILCIAN: Ician: certifica ector, p	Be	25. Was case referred to medical examiner? 1 Diver 25 No. Hospital:		O#	200	n (Check only one		
Physical diagrams	10	1 ☐ Yes 2 ☐ No 1105 Pital 11☐ No 27. Magner of Diatr 28a. Dite of	Injury 28b. Time of	III JUOA	4 Nursing no	me 5 Resider 28d. Describe hov	nce 6 Other (Speci	fy)
ding th. After	tlon	1.5 Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	Day Year) Injury	Wo	rk? Yes 2 □ No	200. 200020	Tanjuny Gudan.Gu	
IVISION OF VITA or Attending Physician: ter death. Irector: After this certific n by the funeral director.	flca	3 Suicide 6 Could not be	f Injury - At home, farm, st				eet and Number or Rur	al Route Number,
a afferd	Certification;	4 ☐ Homicide determined building	g, etc. (Specify)			City or Town,	State)	
ospit hours unera ly fille		29a. Certifier Certifying Physician: To the base (Check only 2 Medical Examiner: On the base	est of my knowledge, deat	th occurred at the til	me, date and place,	and due to the cau	use(s) and manner as	stated.
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, age	ledical	one) and manne	r stated.					
To To To To To To To To To To To To To T	Σ	29b. Signature and title/pf certifier		29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
		, 102/03	37 E	144	J4+1		4/25/	100
(10)		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print)	10.11	,	1 //1-1	ci 11
	tata	31. Date filed (Month Day, Year)	gistrar's Signature_	VW	non by	ton 1	TOVEND.	A 41099
Regis	state strar	MAY 0 1 2006	w & don	Ale)	,			,
DHMH 17 Rev 1	1/2001							

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of rtificate of			giene Reg. No.2006	15116		
	Physici /Medic		1. Decedent's Name (First, Middle, La Velma D A	rtis				2. Date of Dea Month April	26, 200	3. Time of Death 10:10PM		
	Examin		4a. Facility Name (If not institution, giv Suburban Hosp			4b. City, Town, Bethe	or Location of Deal sda		4c. County of De Montg			
	Funeral Director			ex 7. Age	(In yrs. last birthday, Yrs.	Months Day:			Year) 951 9.8	irthplace (State or Foreign Country)		
	Maryland	tor	Usual Residence of Decedent 10a. State MD 10b. County P • G •		10c. City, Town or L Upper I	ocation Marlbor	0			10d. Inside City Limits 1 X Yes 2 □ No		
	h with the	al Director	10e. Street and Number 4711 Colonel	Ewell Cou	ırt	10f. Zip Code 20	772		10g. Citizen of What U.S. A.	Country?		
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23s or 28s-f ahow aumatic avant, the Madical Experimental be callified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Ppivorced	12. Was Decedent E Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No.	Hispanic Origin? (S ban, Mexican, Puel o Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, WI Specify: B			
Maryland 21215-0036	d within 72 ho piene. r than "natur the May cal	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give		upation e during most of wo ed) Manager	orking	Access Priva	is/Industry Intelegence te Company		
land.	uld be filed Aental Hygis rked other tic avant,	To Be C	17. Father's Name (First, Middle, Last, William A. Gr	aham			18. Mother's Na Mary	me (First, Middle, Best	Maiden Sumame)			
	is 1 and 2 should of Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (William Artis		6	834 Amb	er Hill	ural Route Numbe Court		lle,MD 2074		
Baltimore,	000====		20a. Method of Disposition 1 □ 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		Snow H	osition (Name of matery or other p LITI CEII	etery Ma	y 2,06	Snow Hi	Town, State 11, N.C.		
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Soneral Service Lice	EXUL	lusey		n Funer	al Home	1313 6t	C. 20001 h St. N.W.		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. LVM	CARCI	NOMA	ying, such as cardia	ic or respiratory ari	rest,	Approximate Interval Between Onset and Death		
8760,	Examiner	dical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 shruid be delached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the second of	Fetal death 3	□Ectopic pregnar □ Other (specify)	су		23d. Date of o Month	lelivery Day Year		
_	quires that in signed b uld be deta	þ	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause o	given in Part I.			to the cause of death? Probably 4 Unknown		
Division of Vital Records,		Completed					 	24a. Was a autop perfor	rm of prior t	autopsy findings available o completion of cause of ? es 2 ☐ No		
VII.	Physician: The l this certificate har ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpatie	nt 30 ma	ther	eath Check only of	nel lence 6 □Other (S	naciful		
ion of	ding After fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dale of Injun (Month, Day		of 28c. In	<u>_</u>		ow injury occurred	Journal		
DIX	safter d'ati	Certifle	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, farm, s . (Specify)	treet, factory, offic	8	28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,		
	to the Hospital or At within 24 hours after of the Funeral Direct completely filled in by	edical (nysician: To the best o miner: On the basis of and manner stat	examination and/or i							
	To the Within 2 To the Comple	Me	29b. Signature and title of certifier	A. a.			nse number		29d. Date signed (Mo			
2	(10)		30. Name and address of person who	completed cause of de	path (Item 23a) (Type	, Print)	# (100)	Repleter	04/27/0 9 pm =	1027		
	Sta	ate	VICTOR M. PRIEGO 31. Date filed (Month, Day, Year)	Registra	r's Signature_		7/ 100	DI I TUBPX	mo?	-		
	Regist	rar	MAY 0 1 200	6 Elder	1 los	all I						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 04 2006 1125 AM Charlotte G. Acker /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number Dicimico SAUS by
II Under 1 Year | If Under 24 Hrs. Medical 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs 85 Director 103-14-4397 Jan. 26, 1921 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 □Yes 2 No Director MD Wicomico Delmar 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with or itema 23a or U.S.A. 21875 104 Woodlawn Avenue Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "ne any injury or other traumatic avant, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christine Molfenter Frank Ervin Stever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Woodlawn Avenue Delmar, MD (Husband) Donald H. Acker 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Melson's Cemetery 04-30-2006 Delmar, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Delmar, DE 13 E. Grove St. 23a. Part1. Effer the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear value. List only one earls on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aclenocaranoma 1 Concreatic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or sella consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been significant cannot be page 2 should t 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funeral director, pag 2□ No 1 ☐ Yes 2 1 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manus of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident M To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 054127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis mo 100 Power Hon 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 1 2006 Registrar

	•	For State Registrar	State of Maryla				lealth a <i>Death</i>	and Me		giene Reg. No.	006	15118
Dhunisia		1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea		Year	3. Time of Death
Physicia /Medic	al .	Wilhelmina Anders							04/24/2			11:55 P M
Examine	er	4a. Facility Name (If not institution, give Doctor's Communit				y, Town, o l ham	r Location of			Pı	County of Death rince Ge	
Funeral Director		407-38-8275	7. Age (In yrs	s. last birthday) Yrs.		er 1 Year s Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 01/14/	h Y. Year) 1929	Cou	place (State or Foreign ntry) cucky
and	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
Mary -feho lied a	ţ	Kentucky Letcher	Je	nkins								¥∏Yes 2□No
h the	Director	10e. Street and Number			10f. Z	Zip Code	·			10g. Citi:	zen of What Cou	intry?
23a c	a D	340 B & O Hill				537				USA		
should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-f ehow eumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:			edent of Hoecify Cuba 2X No		gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)		14. Race - Ameri Black, White Specify: Whi	, etc.
hour stural		15. Decedent's Ed		16a. Dece	dent's Us	sual Occup	ation			16b. Kir	MILI nd of Business/Ir	
d within 72 hours af giene. Ir than "natural", or Ire Medical Evam	Completed	(Specify only highest grades) Elementary/Secondary (0-12) 12		(Give	kind of v DO NOT	vork done use retire	during most d)	t of workin	g	Nat	ional graphic	,
buld be filed Mental Hyg arked othe atic event,	o Be C	17. Father's Name (First, Middle, Last) Carl Melvin Mull	ins, Sr.						(First, Middle, ne Mor		Sumame)	
shoul nd Me mark	ř	19a. Informant's Name/Relationship (7		19b. Mailir	ng Addre	ss (Street					r Town, State, Zi	p Code)
and 2 st alith and 127 ts n er treun		Susan Leslie Dick	erson/ Daught	er 5710	Rav	rensw	ood Ro	oad R	iverda	1e, 1	MD 20737	7
ges 1 g t of He If item or othe	18.	20a. Method of Disposition 1XX8urial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispo cemetery, cres	natory of	r other pla			ate		cation - City or T	own, State
t. Pag tmen tent: njury	1	4 □ Donation 5 □ Other (Specify		ise Cem		•			9/2006			cal Home
permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked eny injury or other treumatic events.		21. Signature of Faheral Service Licen	S 6 6				-	-			D 20715	ar nome
Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the dea one cause on each line. Myocardial				ng, such as o	cardiac or	respiratory ar	rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse									
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uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
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that the death certificate be executed ed by the attending physician and detached for use as the buriel-transit	Physiclan/Me	in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\overline{\text{N}}\) No	23c. If yes, outcome of preging the live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic Other (pregnanc (specify) _	4			2	23d. Date of deliv Month	very Day Year
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se re e	۵	Part II. Other significant conditions of Diabetes Mellitu		esulting in the u	naenying	g cause giv	ren in Part I.					bably 4 Unknown
The ta	Completed								24a. Was autop perfo 1 Yes		24b. Were aut prior to co death?	opsy findings available ompletion of cause of 2 \(\times\) No
ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o			
g Phys er this eral dir	ဥ	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1X Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f	28c. Injui Wo	ry at rk?	2	ne 5 Residente 1		Other (Special of the Control of the	ify)
or Attending after death. Director: After d in by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		home form st	M		Yes 2 1		Rf. Location /	Stroot and	d Number or Pu	ral Route Number,
el or Ats s after of el Direct	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)	геец, таск	ory, onice		2	City or Tov	vn, State,)	ai ribute Number,
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	edical ((Check only one)	ywician. To the best of my kn niner: On the basis of examin and manner stated.	nowladge deat nation and/or in	vestigati	ed at the ti on, in my o	me, data and opinion, deat	d placa, a th occurre	nd due to the d at the time,	cause(s) date and	place, and due	ttated. to the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	- 00 -		2	9c. Licens	se number			29d. Date	e signed (Month	, Day, Year)
		Mertor 10	(MI)		I	02676	5			04/2	5/2006	
		30. Name and address of person who				n - 1	C	210	C 4 1	C	ing M	20010
		Hector Collison, 31. Date filed (Month, Day, Year)	M.D. 8401 C		LIE I	Koad	Suite	310	Silver	Spr	ing, MD	70310
Sta Registr		APR 2 8 20	06	A	W.	,						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#10qperFH5/1/06,BMW,MbCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 28, 2006 **Physician** ASSUNTA CANIGLIA ANTONELLI 2:45PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Rockville Shady Grove Nursing and Rehab Montgomery 8. Date of Birth Month, Day, Year) April 3, 1915 Birthplace (State or Foreign Country)
 LEALY If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 200 F 91 578-52-1753 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 TYes 2 □ No Rockville Montgomery Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number Italy #909 United States 9701 Medical Center Drive 20850 Amer L Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Never Merried 2 Married _{Specify:} White 1 ☐ Yes 2 ☐ No Specify: Completed by 3 → Widowed 4 □ Divorced Year or Detes: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Alba DiPompo Vincenzo Caniglia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13604 Monarch Vista Drive, Germantown, MD 20874 Raffaele Antonelli - Son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ft. Lincoln Cemetery 05/02/06 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Hines Rinaldi Funeral Home, Inc 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Demontia Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Physician/Medical Examiner ig physician end es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□Yos 2FT10 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient this 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 5 Pending investigation 1 ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician: The law requires thet the death certificete be executed Division of Vital Records, P.O. Box 68760, i efter deeth.

I Director: After this of in by the funerel d within 24 hours e To the Funeral D completely filled To the within 2

Baltimore, Maryland 21215-0020

6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Macket Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30-Name end address of person who completed cause of death (Item 23e) (Type, Print)

15225 Shady Grove Road, Suite 208, Rockville, MD 20850 MD

Shahryar Davari 31. Dete filed (Month, Day, Year)
MAY 0 1 2006

3. Registrer's Signature

Registrar DHMH 16 Rev 6/95

06-02840 Terry Lee Arnold Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Mygiene

		I- For State Registrar	Ce	ertificate o	of Death		R	eg. No. 200	6 12121
Physicia	_	Decedent's Name (First, Michael	ddle,Last)				Date of Dea Month		Time of Death
edical Examin	er	TERRY LEE	ARNOLD				April 26, 2	Day Year 2006	2240 hrs
		4a. Facility Name (if not institu	ution, give street and number)		4b. City, Town, o			4c. County of Deatl	1
		14201 Seneca Road	d		- Darnestow	" Genn	antown	Montgomery	
Fun é ral		5. Social Security Number	6. Sex 7. Age (In yrs	last birthday)	If Under 1 Ye			th(MM/DD/YYYY) 9. Bir Foreig	
Director		215-44-5648	1X M 2 F 58	Yr	Months Da	ys Hours	Min. Jan.	14,1948	untry) WV
	H	Usual Residence of Decedent					1		
any	ı	10a. State 10b. Count	Trederick 10c. Cit	y, Town or Loca		.1	.11		10d. Inside City Limits
* .	_	Md. — Mor	ntgomery G	ermanto	wn Bu	rkitts	sville		1 X Yes 2 X No
arylar Sa-f s	왌	10e. Street and Number	6 E. Main St	reet	10f. Zip Code		21718 ¹	0g. Citizen of What Cou	ntry?
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vith the s 23a s 23a	ᇹ	11. Marital Status	12. Was Decedent Ever in	U.S. 13. W	as Decedent of H	lispanic Orig	in? (Specify Yes or No	- 14. Race - Amer	ican Indian, Black,
eath w items ist be	Funeral	1 Never Married 2 X	Married Armed Forces?	lf '	Yes, specify Cuba	an, Mexican,	Puerto Rican, etc.)	White, etc.	
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5-0036 iled within 7/ Hygiene. I other than the Medical	힐	12		Prof	essional	Skyd	iver	Rigging	
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215 be file ntal H rked ent, t	Be (Lawrence Arno	o1d			Syl	oil Dumire		
7 21215-0036 hould be filed within 72 hours after and Mental Fygiene. is marked other than "natural"; tire event, the Medical Examiner.		19a. Informant's Name/Relatio			,			mber, City or Town, State	
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more, MD 21215-0036 Propes I and 2 should be filed within 72 hours after death with the Maryland che for Fleath and Montal Higgiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she content transmatic event, the Medical Examiner must be notified at once	ſ	20a. Method of Disposition		o. Place of Dispo crematory or o	osition (Name of control	emetery,	May $\overset{\text{Date}}{\mathbf{l}}$,	20c. Location - City or	Town, State
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uit Partme	ŀ	4 Donation 5 Other 21. Signature of Funeral Servi	Spean).	22.	Name and Addre	ss of Facility	DeVol Fune		.,
Baltimore, I permit Pages and Department of Heal Important: If item injury or other tra	1	Jeffrey Titco	omb per dvr	1	O East D	eer Pa	Devoi Fune ark Dr. Gai	eral Home Lthersburg,	Md. 20877
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/Medical	П	failure. List only one cau	Address - Installa Condition	ovascular Di	sease				8etween Onset and Death
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Box 68760, e death certificate be executed the attending physician and ted for use as the burial - transit	edical	UNPENDED	X AMENDED item#4	b.perME.g	855.5/26/0	6 TT 1 ()b-f per fb	g856 6-5-0)6 vt
50, te be rysici	eg l	IF FEMALE:	23c. If yes, outcome of pro		055,5/20/0	0 11 10	D I PCI III	23d. Date of deliver	
	2	23b. Was decedent pregnant in past 12 months?			etal death 3	Ectopic	pregnancy		Day Year
th cer trendi	Physicial		4 Pregnant at time of	al a a the	Other (Specify)				
Bo e dea the a	<u>ş</u>		Unknown 9 Unknown						
n of Vital Records, P.O. Box 6876 rding Physician: The law requires that the death certificat has the this certificate has been signed by the attending phe funeral director, page 2 should be detached for use as the	b P	Part II. Other significant con	nditions contributing to death but no	t resulting in the	underlying cause	e given in Pa		obacco use contribute to	
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Signature After After dear dear dear by the by the	<u>iz</u>		nvestigation 28e. Place of Injury - Ai	home, farm, str	eet, factory, office	building, et	c. 28f. Location (Street and Number or R	ural Route Number, City
Division of Vital Records, P.O ral or Attending Physician: The law requires that I ra after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deared	Certification:	de	Could not be letermined (Specify)		,		or Town,		
Division To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the		29a. Certifier	g Physician: To the best of my knowl	edge, death occ	urred at the time	date and pla	ace, and due to the cau	se(s) and manner as sta	rted
the H hin 24 the F	ica		Examiner: On the basis of examination						
To with con	Medical	29b. Signature and tyle of cer	and manner stated		29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)
5	_	11/1	I do In		0.0	C.M.E.		April 27, 2006	
		7101		220)					· · · · · · · · · · · · · · · · · · ·
		30. Name and address of pers Susan Hogan MD.	son who completed cause of death (It Assistant Medical Examin		enn Street Ba	altimore N	MD 21201		
St Regist	ate	31. Date filed (Month, Day, Ye	1 2006 Magaza	13. April	ule				

			For	State of Ma	ryland / De						iene		157101
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П	Physici	an	Decedent's Name (First, Middle, Last							2. Date of Deat Month 04/22/2		Year	3. Time of Death
	/Medic	al	Mildred Agnes Alt 4a. Facility Name (If not institution, give			4h Cih	Town or	Location of		04/22/2	T	inty of Death	6:15 A M
	Examin	er	Holy Cross Rehab &	•	Center		tonsv		Death			TGOMER	v
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birth	day) If Unde	r 1 Year	If Under 24	4 Hrs.	B. Date of Birth		9. Birthp	ace (State or Foreign
	Director		106-09-7582	□M 2XF	92 Yr	s. Months	Days	Hours	Min.	3. Date of Birth (Month, Day, 05/04/1	914	New	York
	and *		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Location						1	0d. Inside City Limits
	Maryl	ō	Maryland Howard		Columbi								1 XYes 2 ☐ No
	7.28e	Directo	10e. Street and Number		COLUMDI		p Code			10	0g. Citizen	of What Cour	ntry?
	hours after death with the Maryland tural; or Itema 23a or 28a-f ahow al Examinant be notified at	ai D	7110 Minstrel Way			21	045				USA		
,	r dea	Funerai	11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes 2 N	ver in U.S.	13. Was Dece	dent of Hi	spanic Origi n, Mexican,	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		Race - Americ Black, White,	
9	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 24∑ N If Yes, Give Year or Dates:	0	1 🗆 Yes	2 X No	Specify:				cifv:	
9500-61212	atura Gal E	ted t	15. Decedent's Edi	ucation	16a. D	ecedent's Usi	af Occupa	ation			16b. Kind o	Whi f Business/Inc	
נוא	Media	ple	(Specify only highest grad	de completed) Coflege (1-4or 5-	+) ((Give kind of wife. DO NOT	ork done a ise retired,	luring most o	of working	7			•
7	ygien ygien f, E	Completed	8		Coo	k							ol System
yland	d off	Be	17. Father's Name (First, Middle, Last)	a d				18. Mother's Bertha		First, Middle, M	Maiden Surr	na <i>m</i> e)	
ج	mark mark	욘	Andrew J. Bouquan 19a. Informant's Name/Relationship (7)		19h A	failing Addres	1_			Route Number,	City or Tox	wn State Zin	Code
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Infinite and 18 an		Edward Andrew Alte			-				916 Ale:			•
e,	ss 1 a of Hea itam othe		20a. Method of Disposition		20b. Place of D				Da			on - City or To	
Baltimore,	Page ment ant: If ury or		1		1	ross C	emete	ry 04		/2006			
391	permit. Departimport Import any inj		21. Signature of Funeral Service Liceo	500						ert E.			al Home
_	005 e d		22a Badi Enter the disease or come	ligations that assessed	the death. De se					d Bowie		20715	Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	A				ardiac or	respiratory arre	15t,		Interval Between Onset and Death
F	hysician /Medical		disease or condition resulting in death)	a	consequence of)	Dem	ent	701					
E	Examiner		0	h									
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of								
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	g phys	-		O							.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
X OX	death certifica e attending ph d for use as th	M/us	23b. was decedent pregnant	23c. If yes, outcome o		3 □Ectopic p	rednancy					Date of delive	,
ים ה	e dea he att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at t		5 Other (s				 -		Month	Day Year
)	w requires that the death certilica been signed by the attending ph should be detached for use as th		Part II. Other significant conditions co		t not resulting in th	ne underlying	Cause dive	n in Part I		23e Did toh	acco use o	ontobute to th	e cause of death?
Hecords,	law requires that as been signed b 2 should be deta	d b	Tarri. Otto alginioani comaniano oc	initioding to doubt bu	it not resulting in th	ie underlying	Jause give	mi ai i aiti.					ably 4 2 Unknown
Ö	w req	ete								24a. Was ar	24	h. Were autor	osy findings available
Ť,	sician: The law sicertificete has b lirector, page 2 s	Completed							_	autopsy	ed?	prior to condeath? 1 Yes	npletion of cause of
	rtifice	Be C	25. Was case referred to medicaf					26. Place o	of Death (1 ☐ Yes 2 Check only one	ES(No	TLITES	28 100
O 1	nysic his ce il direc	To	1 162 2 2 NO	Hospital: 1 Inpatier	nt 2 ER/Outpa	atient 3 D	Othe Othe	4. Nurs	sing Home	e 5 🗆 Reside	nce 6 🗆 (Other (Specify)
בו	Ing P	iuo :	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim	iry	28c. Injury Work	?		d. Describe ho	w injury occ	curred	
ISION	death death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of fnju	ry - At home, farm	M street factor		/es 2 □ No		If. Location (Str	eet and Nu	mber or Rura	l Route Number.
<u>∑</u> :	s after I Dira	Certification:	4 Homicide determined	building, etc		,	,,			City or Town			
	To the Hospital of Attending Physicien: In the Funeral Director; After this certific completely filled in by the funeral director,	ledicai ((Check only 2 Medical Exam	rsician: To the best of	examination and/o	leath occurred	at the tim	e, date and inion, death	place, an	d due to the ca I at the time, da	use(s) and ite and plac	manner as st	ated. the cause(s)
	o than	Med	one) 29b. Signature and title of certifier	and manner stat	ted.		c. License					ned (Month, I	
)	- ≯ - ŏ		1			1	000	5456	06		4/21		•
			30. Name and address of person who c			/pe, Print)					* [
			Sunitha Bhoga	vilei, 122	O A East	TOPPO	fra	d, Se	eite 2	-36 TO	(e) S 01	U, MD	21286
	Sta Registr		Suni Ha Bhoga 31. Date filed (Month, Day, Year) APR 2 5 200	32. Registra	rs Signature	all							4

06-02768 Joanne Ames

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	ato or maryland	Cei	rtificate (th	// (Call 11)	J	eg. No.	n o	5 1512
Physicia Medical Exami		1. Decedent's Name (First, Middle Joanne D		nes					2. Date of Dea Month April 23, 2	Day Yea	r	3: Time of Death 2250 hrs
		4a. Facility Name (if not institution					Town, or Location	n of Death	April 23, 2	4c. County of		
Funeral		Pennsylvania Ave/Alto 5. Social Security Number		e (In vre 1	ast birthday)	Suitla		nder 24Hrs.	In Date of Bir	Prince G	_	
Director			1 M 2 X F	44		Month				, 1961	Foreign	
any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loc	ation						10d. Inside City Limits
* .	_		ngton		rlingt							1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number				10f. Zip			1	0g. Citizen of Wh	at Count	ry?
ith the 23a or notifie		2422 N. 14th St	12. Was Decedent	F	0 140 1		22201			U.S.		
5-0036 led within 72 hours after death with the Maryland atygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Ma	rried Armed Forces?		S. 13. V	Yes, speci	ent of Hispanic Or fy Cuban, Mexica	rigin? (Spe an, Puerto I	ecity Yes or No Rican, etc.)	- 14. Race White		an Indian, Black,
s after rral", o			orced If Yes, Give Year or Dates:		1		X No specify			Specify:		
72 hour n "natu	eted	15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-4 or		16a. Decede during	ent's Usual most of wo	Occupation (Give king life, DO NO	e kind of wo T use retire	ork done ed)	16b. Kind of Bus	siness/In	dustry
5-0036 iled within 72 Hygiene d other than "	Completed by		5+		_	Attor				Ernst&	Youn	g
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene n 27 is marked other than unnatic event, the Medica	Be C	17. Father's Name (First, Middle, I Thomas J. Ames	Last)					er's Name an Be		Maiden Surname)		
21214 hould be fil nd Mental F is marked ttic event, t	ToE	19a. Informant's Name/Relationsh	ip (Type, Print)				(Street and Nu	umber or Ro	ural Route Num	nber, City or Town		
		Kathleen Ames/S	ister	20h F			6th St.	Apt.	#18A Ne	w York (,NY 10017
Sore, ages I an of the Hea		1 Burial 2 X Cremation	3 Removal from Sta	ate Me t	rematory or c	other place) .tan)	Apri	1 28, 006		•	·
Departme Importar njury or	1	Donation 5 Other Special Signature of Funeral Salvice	ecify:	_ Cr	emator 22.		Address of Facili			ral Home		Virginia
	-	23a. Part I. Enter the disease, or c	tank	the death								DC 20007
Physician /Medical		failure. List only one cause of Immediate Cause (Final disease	on each line. a. Multiple Injuries		DO HOL CITIES	the mode (or dying, such as	cardiac or	respiratory arre	est, snock, or nea	n	Approximate Interval Between Onset and Death
⁻xaminer		or condition resulting in death)	Due to (or as a conse		·):						_	
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of	<u> </u>	_			_			
	Examiner	cause. Enter Underlying Cause (Discass or mjury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of	·):	_		_			-	
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ficate be ex g physiciar the burial	/Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcom	a of pregr	onov					Too I b		
68760, certificate be nding physicialse as the burialse as the burialse.	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 F	etal death	3 Ectop	oic pregnan	су	23d. Date of o Month	telivery Da	y Year
P.O. Box 68' that the death certification and by the attending detached for use as:	Physician	1 Yes 2 No 9 V Unkn	own 9 Unknown		3 🗌 (other (Spec						
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for understand the form of the funeral director, page 2 should be detached for understand the form of the funeral director, page 2 should be detached for understand the form of the funeral director, page 2 should be detached for understand the form of the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 3 should be detached for the funeral director, page 4 should be detached for the funeral director of	P P	Part II. Other significant condition	ns contributing to death	but not re	sulting in the	underlying	cause given in P	Part I.				e cause of death?
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Vital Rec ysician: The I his certificate I director, page	OF	25. Was case referred to medical examiner?	T			- 2	26. Place of Death	n (Check or		No 1	√ Yes	2 No
of Vir ling Physic After this funeral dir	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier 28a. Date of Injur		ER/Outpatier 28b. Time of		OA Other 4 28c. Injury at Worl			Residence 6		Scene
ISION C Attending or death ector: Af by the fun	Certification:	1 Natural 5 Pendir	ng Apr 23, 2006	ear)	2226 hrs	11,017	1 Yes 2 ✓	No D		iver vehicle th		road, struck
Ivisior I or Attencather death Director: d in by the	tific	3 Suicide 6 Could	not be 28e. Place of Inj			eet, factory,	office building, e			treet and Number	or Rural	Route Number, City
Di To the Hospital within 24 hours a To the Funeral B		4 Homicide determ	vsician: To the best of my			irred at the	time, data and al		ennsylvania	Ave./Alton		
To the Howithin 24 h To the Furcompletely	Medical	(Check only one) 2 Medical Exam	iner: On the basis of exam	nination an	d/or investiga	ation, in my	opinion, death or	ccurred at t	the time, date a	e(s) and manner a and place, and due	e to the o	cause(s)
	ž	29b. Signature and title of certifie	10 11	1		29c	License number	r		29d. Date signed		, Day, Year)
17	ŀ	30 Name and address of person w	/ho completed cause of di	eath (Item	23a)		O.C.M.E.			April 24, 200)b	
		Susan Hogan MD. A	ssistant Medical Ex	aminer	111 Pe		t, Baltimore, I	MD 212	01			
Sta Registi	ate rar	31. Date filed (Month PR'2) 8	2006 32. Registrar	s Signatur	y. Ap	we		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	ryland		ιπment of Η <i>tificate of L</i>		-	giene Reg. No.	006	15123
	Physici	an	Decedent's Name (First, Middle, Li NELLIE LUCILLE B.						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death	May	8 4c. C	2006 County of Death	5:15 PM
			Upper Chesapeake				Bel Air				arford	
	Funeral Director			Sex 7. Age 1 ☐ M 2 🛣 9(st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 7/14/1	th 17. Year) 915	9. Birthp Cour Ohio	place (State or Foreign http)
	ryland how		10a. State 10b. County		10c. City,	Town or Los					1	Od. Inside City Limits
	the Ma	ecto	MD Harfo.	ra		Ру	lesville			10a Citia	en of What Cour	1 ☐ Yes 2 🌠 No
	uth with the Marylan 23a or 28a-f ahow	ai Dir	5241 Onion Road				2113	32		rog. Cilizi	USA	ttry !
) 0036	tiled within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23s or 28s-f show her, the Medical Examiner must be notified at	Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	1	4. Race - Americ Black, White, Specify: Whi	etc.
50	"natur	eted	15. Decedent's E (Specify only highest gi	ducation rade completed)		16a. Deced	ent's Usual Occupa	ation furing most of works	ing	16b. Kin	d of Business/In	dustry
7	d withir giene. r than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	٠) د			/ Examine:		Ci	vil Ser	vice
(Maryland	ld be ental ked c	To Be C	17. Father's Name (First, Middle, Las Louis Schultz	t)				18. Mother's Name		, Maiden S	Gumame)	
)(¢	s I and 2 shoul f Health and Me Item 27 is mark other traumati		19a. Informant's Name/Relationship Vertis Clinton Be					and Number or Rura			Town, State, Zip 21132	Code)
/8/	Pages 1 announce of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		Cel	metery, crem	sition (Name of natory or other place SS Cemete	a)) 2006		et, MD	wn, State
Balti	permit. Pages Depertment of I Important: if its any injury or o once.		21. Signature of Funeral Service Lice	Longel	lide	e H		meral Hor			lta, PA	17314
				nplications that caused to one cause on each line	the dead.	Do not ente	er the mode of dying	g, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Tesnive	conseque	ence of):	en line	* Ki	dney	teil	we	
	Examiner	_	Sequentially list conditions,	b. newor	nde	crive	conce	r of c	ervix			
= 19	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):						
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S, P.	es that th gned by be detac	by Ph	Part II. Other significant conditions	contributing to death but	t not result	ting in the un	derlying cause give	en în Part I.	23e. Did to	obacco us	e contribute to the	ne cause of death?
Vellie Records,	v requires been sign should be	eted	MRSA OVIN	my tra	1	1 1	Ntect	104	-	Yes 2 🗔	HNO 3∏ Prob	ably 4 Unknown
		Compl	Anema	Thron	ALGO	phi	elor tis	-	24a. Was autop perfo 1 Yes	osy rmed?	24b. Were auto prior to cor death? 1 \(\subseteq \text{Yes} \)	psy findings available mpletion of cause of 2 No
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on of	ding h. After fune	tion: To	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day		R/Outpatient 28b. Time of Injury	28c. Injury Work	4 Nursing Ho	me 5 ∐ Hesid 28d. Describe h			0
Seleh	of or Attendate after death Director:	Certification:	3 Suicide 6 Could not l	De Olean of Laine	y - At hor (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tov		Number or Rura	I Route Number,
(T)	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the beg of miner: On the basis of e and manner state	exam≀natio	ladge, death on and/or inv	contined at the flat estigation, in my op	is date and place in pinion, death occurre	and due to the ed at the time,	causo(s) a date and p	ind industrier as at place, and due to	ated. the cause(s)
	To the within 2.	ž	29b. Signature and title of certifier	A.		_ \	29c. License	number		29d. Date	signed (Month,	Day, Year)
	1		30. Name and address of person who	completed cause of do	ath /Item	23a) (Tunn 1	DD1	503/90		Mai	1 -1, 4	2000
	U		Apriva Desa	500 U	pe	Che	sapat	ReDr. 1	Bel A	CM	10 21	1014
7	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registra	Signatu	ire			0-	,		1

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State of Maryland / Department of He	ealth and Mental Hygiene O O

partment of Health and Mental Hygiene 🔠 📙 🖯 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Carran Leota Brown-Russell Month Year 9:33 AM MAY 2006 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 06/28/1943 7. Age (In yrs. last birthday) 62 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 1 M 2 XF 175 34 9988 Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "naturel", or iteme 23a or 28a-1 ehow the Medical Examiner must be notified at 10d. Inside City Limits VA Lorton Fairfax 1 Tyes XX No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 22079 7631 Highland Woods Court #A3 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Executive Assistant Health Care or other traumatic event, permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pearly Brown Dorothy Garrett ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7631 Highland Woods Ct #A3/Lorton VA 22079 Herbert Russell (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l Cemetery 5/16/06 Triangle VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral and Cremation Services Annapolis and Falls Church Melanie Willed 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** virutor /Medical s a consequence of) Examiner taliz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician end for use as the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day signed by tha at d be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificete 1 ☐ Yes 2 1 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 DER/Outpatient 3 DOA this the Funerel Director: After the 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Directompletely filled in by 4 \(\text{Homicide} \) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D5/398 s of person who completed cause of death (Item 23a) (Type, Print) 575 Main Street Suite 351 Laurel Md 20161 James H. Shero, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Blown to porte **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Bryant Raymond MAY 2006 10 8:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND <u>ALLEGANY</u> 8. Date of Birth Nov 12, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**□M 2□F 220-30-8353 69 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Worle permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show with Injury or other traumatic event, Ita Myclical Examinating must be cotified at once. Allegany MD Cumberland Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21502 USA -135 North Mechanic Street Apt. 208 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status tX Yes 2 No If Yes, Give 1957-60 Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Bryant Charles R. Bryant 19a. Informant's Name/Relationship (Type, Print)
Preston Bryant 19b. Mailing Address (*Street and Number or Rural Route Number, City or Town, State Tin Code*) 241 New Hampshire Ave Cumberland MD 21502 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Rocky Gap Veterans Cemetery 1 Burial 2 Cremation 3 Removal from State 5/15/2006 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Fuheral/Service Licenses 22. Nan Scarpetti Pune in Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** entricu 30 minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ₫ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, cete hes been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No holesterolemi certificete 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ▼ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending efter death.
Director; Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours e To the Funeral C completely filled i Hospital 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ÷ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 10, 58853 2006 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Pennsylvania

Cumberland, Maryland 21502

Avenue

ORIGINAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Habib Chotani

31. Date filed (Month, Day, Year)

06-03074 Felix Warner Brisco

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		For State Certificate Registrar	ate of Death	Reg. No.	5 5 2
Physicia dical Examir		1. Decedent's Name (First, Middle,Last) Felix Warner Briscoe		2. Date of Death Month Day Year May 7, 2006	3. Time of Death 0010 hrs
		4a. Facility Name (if not institution, give street and number) Southern Maryland ER	4b. City, Town, or Location of Death Clinton		
Funeral Director		5. Social Security Number	nday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	Foreig	
ow any		Usual Residence of Decedent 10a. State	or Location e Hills		10d Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Coun	
ith the 1 23a or notified		4800 Tamworth Court 11. Marital Status 12. Was Decedent Ever in U.S.	20748	U.S.A.	
	y Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify: 	Pecify Yes or No-Rican, etc.) 14. Race - Americ White, etc. Specify: B 1 a c	
hours a natura Examin	ed by		Decedent's Usual Occupation (Give kind of Juring most of working life. DO NOT use ret	work done 16b. Kind of Business/Ir	_
5-0036 iled within 72 hou Hygiene J other than "nau the Medical Exa	Completed	1 2 College (1-4 or 5+)	ation Attendent	Metro /Pi	ivate
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Ned	o Be C	17. Father's Name (First, Middle, Last) Louis Briscoe 19a Informant's Name/Relationship (Type, Print)	Pear1	(First Middle, Maiden Surname) Elizabeth Aller	1
MD 21 nd 2 should alth and Men m 27 is man aumatic ev	ř	Pearl E. Briscoe/Mother 60	Mailing Address (Street and Number or 604 Piney Branch	Rural Route Number, City or Town, State, Rd.NW Washingto	Zip Code 20012 n.DC
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I litem 27 is marked or other trammatic event,		20a, Method of Disposition 20b. Place of Cremation 3 Removal from State	f Disposition (Name of cemetery, ory or other place)	Date 20c. Location - City or 16/200 prentwood	Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If iten injury or other tr	4	4 Donation 5 Other Specify: FORT 21. Signature of Funeral Service Licensee		nald Taylor III	
		13. C. Shylor	110583 Middlepor	t Ln.White Plain	s,MD 206
Physician /Medical Examiner		23a. Part I. Enter the disease, or inclications that caused the death. Do not failure. List only one cause in each line. Immediate Cause (Final disease a. Atherosclerotic card		r respiratory arrest, shock, or heart	Approximate Interva Between Onset and Death
FAMILIE		or condition resulting in death) Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			10
e executed cian and rial - transit	Medical	Xunpendedamended item#23a,27,	erME,g855,5/25/06 TT		
8760, ificate be ex ng physician is the burial	_	FFEMALE: 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregna	23d. Date of delivery	ay Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - trans	Physician	past 12 months? 2 1 Yes 2 No 9 Unknown 2 4 Pregnant at time of death 5 9 Unknown	Other (Specify)	ncy Month Di	ay teal
P.C es that igned	ক্র	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to to 1 1 Yes 2 No 3 ✓ Proba	
cords	Completed				opsy findings available impletion of cause of
E - '5 -	انه	25. Was case referred to medical	26 Place of Death (Check	only one)	2 No
F Vita	10 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou 7. Manner of Death 28a. Date of Injury 28b. T		g Home 5 Residence 6 Other:	
on of ending Ph eath or: After t	ţioii	1 X Natural 5 Pending (Month, Day, Year)	ime of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, far (Specify)	m, street, factory, office building, etc.	28f. Location (Street and Number or Rura or Town, State)	al Route Number, City
o the Hosi ithin 24 hc o the Func ampletely f	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat one) 2 Medical Examiner: On the basis of examination and/or in and manner stated			
5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Me	29b. Signature and hitle) of certifier	29c. License number O.C.M.E.	29d Date signed (Mont	h, Day, Year)
Bi		30. Name and address of pers in who completed cause of death (Item 23a)			
VJ	- 1	Susan Hogan MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 21	201	

Roger Linwood Banks, Jr.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 15127

		1- For State Registrar		Cei	rtificate o	f Deatl	h			Re	g No.	JUI)	
Physici		Decedent's Name (First, Midd	le,Last)							Date of Death Month	Day Yea		B. Time of Death	
Medical Exam	iner		inwood Ba		Ι					pril 19, 20		31	0322 hrs	
		4a. Facility Name (if not institution 3314 Branch Avenue	in, give street and nu	umber)		4b. City, T Temp	own, or Lo le Hills	ocation of	Death	_	4c. County Prince (3	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs I	ast birthday)	If Unde	er 1 Year	If Under	24Hrs. 8	Date of 8 irt	h (MM/DD/YYY)	9. 8irth	place (State or	
Director		579-97-0033 Usual Residence of Decedent	1 M 2 F		28Yr	Month:	Days	Hours	Min.	06/10/	1977	Foreign Cour	Wash., DC	
ńut		10a. State 10b. County		10c. City,	, Town or Loca	tion							10d. Inside City Limits	
d how a	_	D.C.											1 X Yes 2 No	
ırylan la-f si	cto	DC 10e. Street and Number				10f. Zip	Code	W.	ashin	gton	g Citizen of WI			
ith the Maryland 23a or 28a-f show any notified at once,	Director	2244 Savanna	h Town	SE #14				200	20					
with the s 23a s 23a		11. Marital Status		cedent Ever in U	S 113. W	as Decede	nt of Hispa			y Yes or No-			States	
eath ritem	Funeral	1 X Never Married 2 M	arried Armed F	orces?					Puerto Rica			e, etc.	arr maiari, oldok,	
ifter o	by F	3 Widowed 4 Div	orced If Yes, Give Yes		1	Yes 2	X No	specify:			Specify:	В	lack	
1036 Within 72 hours af iene er than "natural Medical Examin	d b	15. Decedent's Education (Spe	cify only highest gra-	de completed)	16a Decede	nt's Usual (done	16b. Kind of 8u	siness/Ind	dustry	
336 thin 72 P ne than "r edical E	oleted	Elementary/Secondary (0-12)	College (*	1-4 or 5+)	during	nost of wor	King ille L	JO 1401 U	ise relifed)					
withii siene rer th	omple	12th			1	I	abor						vate	
15-C filed v il Hygi ed oth	O	17. Father's Name (First, Middle,		D 1	7		18	3. Mother's			laiden Surname	,		
21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica	o B	19a. Informant's Name/Relations	r Linwood	Banks,		a Address	(Street :	and Numb				en Ly1es City or Town, State, Zip Code)		
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiens (rea 27) and art of the art of the art of the art has "natural", or items 23a or 28a-f 5the traumatic event, the Medical Examiner must be notified at once	_	Rodger L. Ba	nks. Jr./	Father							, Wash			
Battimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Operamen of Health and Mental Hygene Important: If item 27 is marked other Initing yor other traumatic event. the Med		20a. Method of Disposition		20b. I	Place of Dispo	sition (Nam	ne of ceme	etery,		ete // I	20c. Location			
Baltimore, permit. Pages I an Department of Hes Important: If ite		1 X Burial 2 Cremation		l l	crematory or o			1-	4./20	12006	T J.		MD	
attir nit. F sartme oorta		4 Donation 5 Other State 21. Signs ture of Funeral Service		пал	rmony M						Lando			
Balt permit. Depart Impor injury		John T	leral Service Licensee 22. Name and Address of Facility Stewart Funeral 4001 Benning Rd., NE Wash.,										20019	
Physician		23a. Part Enter the disease, or failure. List only one cause	complications that on each line	aused the death	. Do not enter	the mode o	of dying, s	uch as car	rdiac or res	piratory arre	st, shock, or he	art	Approximate Interval	
/Medical xaminer		Immediat Cause (Final disease		ounds (2) to	head and I	eft foot						- 1	Between Onset and Death	
		or condition resulting in death)	Due to (or as a	a consequence o	f):									
	ē	Sequentially list conditions, if any, leading to immediate	b	a consequence o	f):									
	in in	(Disease or injury that initiated	С.											
ed nsit	Examiner	events resulting in death) Last	Due to (or as a	consequence o	f):									
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760, icate be exe physician a	an/Medical	IF FEMALE:		outcome of preg				**			I and a			
68760, ertificate be ding physici e as the buri	٦	23b. Was decedent pregnant in the past 12 months?	e 1 Live b			etal death	3	Ectopic	pregnancy		23d. Date of Month	Da	y Year	
Box 6 Re death cer the attendi	Sici			nant at time of de	eath 5 0	ther (Spec	cify)				ì			
be des	Physicia		9 Unkno											
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Records, The law require	Completed									24a Was a autops	y i	orior to co	psy findings available mpletion of cause of	
Rec The cate	Ö									perform 1 V Yes 2		death? ✔ Yes	2 No	
tal Rection: The certificate ector, page	Be (25. Was case referred to medical examiner?	(Josephal)			2			Check only	one)				
of Vital ig Physician: ther this certi	ျ	1 🗸 Yes 2 No		Inpatient 2	ER/Outpatien		ÿ/\		Nursing Ho		Residence 6		Scene	
n of ding Ph. h. After t	Ë	27. Manner of Death 1 Natural 5 Pend	28a. Date (Month Apr 19,	of Injury Day Year) 2006	28b. Time of 0000 hrs	Injury 2	8c. Injury		lsul	I. Describe h oject shot	ow injury occurr	ed		
ivisior for Attend after death. Director:	cati	2 Accident Inves	tigation					s 2 🗸 l		·				
Division of Vital Records, P.O. Box 68760, 4 hospital or Attending Physician: The law requires that the death certificate be executed by hours after telector. After this certificate has been signed by the attending physician and tely filled in by the funeral director.	Certification:	deter	a not be	e of Injury - At ho Parking Lo		et, ractory,	office but	liaing, etc.		or Town, St	ate)		I Route Number, City	
lospit 4 hour funer		4 ✓ Homicide 29a. Certifier 1 Certifying Pt	ysician: To the bes			urrod at the	time date	and place	_		Avenue, Te			
Di To the Hospital of within 24 hours a To the Funeral I	Medical	one) 1 Certifying Property one 2 Medical Example 1	miner: On the basis	of examination a	nd/or investiga	ition, in my	opinion, o	e and plac death occi	urred at the	to the cause time, date a	e(s) and manner ind place, and c	as starte lue to the	cause(s)	
T. W. I.	Me	29b. Signature and title of certifie	and manner s	tated		29c	License	number			29d Date sign	ed (Mont	h, Day, Year)	
		(alsun	, o AC				O.C.M	.E.			April 19, 20			
		30. Name and address of person	who completed caus	se f death (Item	23a)									
RU	10		Assistant Medic	al Examiner	111 Per	nn Stree	t, Baltin	nore, M	D 21201					
	ate	31. Date filed (Month, Day, Year)	37 Re	egistrar's Signatu	ire.	100			_			-		
Regist	rar	<u>ΜΑΥ 0 3 2</u>	106	we to	15/20	4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 24 2006 er 1:50P M **Physician** Tamara Rosemary Bowman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North, 2ay, Year 9 4 6 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Rhode Island 1 □ M 2 🖵 F 59 Yrs. 037-30-2853 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23s or 28s-f show the Medical Exacultar must be notified at 1 Yes 2 No Lusby by Funeral Director Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 12971 Pine Place United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, tra Medical Expense. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) private school public school College (1-4or 5+) Elementary/Secondary (0-12) elementary school Teacher <u>5+</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Timtschenko Robert Emmett Tait ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12971 Pine Place Lusby, MD 20657 Marvin E. Bowman- husband 20b. Place of Disposition (Name of cemetery, crematory or other place) May 2, 20c. Location - City or Town, State 20a. Method of Disposition 1 Hurial 2 Cremation 3 Removal from State East Providence RI 4 ☐ Donation 5 ☐ Other (Specify) Lakeside Cemetery 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final disease or condition resulting in death) Breast cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) cete has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No After this certification, I or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Hospital Rd suite 212 110 31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registras Signature 2005

D0059061

Prince Frederick MD 20678

Registrar

Amend #'s 11,17,19A Per FD 5-2-06 A.A.Co.Health Dept. PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of Man		artment of H rtificate of I		Re	g. No. 2 U U 6	15130
á,	Physici		1. Decedent's Name (First, Middle, La Maude Virginia	,				2. Date of Death Month Apr.	25, 2006	3. Time of Death 10:30a M
	/Medic Examir		4a. Facility Name (If not institution, given 822 Oak Grove C	ircle		Seve	Location of Death		4c. County of Death	rundel
2000 1000	Funeral Director			Sex 7. Age (I 1 ☐ M 3 4€] F	78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep. 12		place (State or Foreign intry) MD
	a-f show	ctor	MD 10b. County Anne A		Oc. City, Town or Lo	Severna	Park			10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	ai Director	10e. Street and Number 822 Oak Grove C.	ircle		10f. Zip Code 21	146	10	g. Citizen of What Cou US	-
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other then "naturel", or Iteme 23s or 28s-f show or other treumatic event, the Madicial Examinar must be nutilised at	d by Funerai	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tes 200 No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-(d within 72 h jiene. r then "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired HOMEMA	during most of work ()	aing 1	6b. Kind of Business/Ir Ho	ome
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, the Ms	To Be C	17. Father's Name (F Usabo le, Last Richard Issac D	uvall			Muriel	e (First, Middle, M Edwina l	Poehler	
	and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationsing Barbara Tracy						City or Town, State, Zi a Park, MD	p Code) 21146
Baltimore,	permit. Pages 1 and: Department of Health Important: If item 27 eny injury or other tr once.		20a. Method of Disposition 1X Burial 2 Cremation 3 (4 Donation 5 Other (Speci	Removal from State	20b. Place of Dispo cemetery, crea MD Vetera	matory or other plac	e) Apr	28, 006	Oc. Location - City or T	
Balti	permit. Pag Department important: eny injury c		21. Signature of Juneral Sowice Lice	Su	Ba	2. Name and Address arranco & 95 Gov. ri	Sons, P.	A. Severi	na Park Fur na Park, MI	neral Home 21146
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	plications that caused the one cause on each line. Due to (or as a c	feslitionsequence of): Diad	der the mode of dying of the Ca	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):					
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal déath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
rds, P.	w requires that been signed t should be deta	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	
of Vital Records,		Completed						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
Vit	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 Property 1	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA Othe		h (Check only one)	ce 6 ☐Other (Special	, ,
Division of	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral or	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	28b. Time o	28c. Injury Work		28d. Describe how		<u> </u>
Divi	ital or Att urs after d ral Direct iled in by i		4 Homicide determined	building, etc. (Specify)			City or Town,		
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	edicai	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exe	hysicien: To the best of n miner: On the basis of ex and manner stated	amination and/or in	h occurred at the tim vestigation, in my or	ne, date and place, pinion, death occurr	and due to the cau red at the time, dat	ise(s) and manner as s e and place, and due to	stated. the cause(s)
	To the within: To the comple	×	29b. Signature and title of certifier	Mala		29c. License	$\frac{13}{3}$	290	d. Date signed (Month,	Day, Year)
A.	Sta Regist		30. Name and address of person who	2006 32. egistrar's	5 Na	Print)	my Gle	Dun	10 2	106/

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

in then "natural", or items 23a or 28a-f show the Modical Examiner cost be notified at

Director

Funeral

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Be Completed

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mit. Pages 1 and 2 should be partment of Health and Menta portant: If item 27 is marked y injury or other traumatic ev permit. Page Department of important: if eny injury or once. 21. Signature of Fus, val Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirt, or heart failure. List only one cause on each line. Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Physician/Medical IF FEMALE: 23b. Was decedent pregnant signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be P the Funeral Director: After the 27. Manner of Death Certification: within 24 hours a 1 _ Certifying Physicien: To the best of my knowledge idettriocourse at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Tal 3001 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 27 2006 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink

Andrew Joseph Baker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day April 20, 2006 0243 hrs Medical Examiner Andrew Joseph Baker c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Surburban Hospital Bethesda 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Days Director 638-12-0437 20 Mar. 31, 1986 Country) Texas 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 YYes 2 No Texas Stephenville Erath should be filed within 72 hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country notified at 1488 Postal Route 1562 76401 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes Give Yea Yes 2X No specify: White Specify: Widowed 4 Divorced ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Army Soldier 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel J. Baker Joanne Kuster Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ Brown Mortuary Affairs 106 Custer Rd. FT MYER, VA Pages 1 and 2 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) = = 1 Burial 2 X Cremation 3 Removal from State 4/27/06 Important: injury or otl Sundown Crematory Mineral Wells, Texas Ponation 5 Other Specify 22. Name and Address of Facility ature of Funeral Sen Murphy FH 4510 Wilson Blvd. Arl., VA 22203 23a. Par Enfer the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED ending physician use as the burial -UNPENDED 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö ě مَ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 After this certificate 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes No 28a. Date of Injury (Month, Day Year) Apr 20, 2006 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 28c. Injury at Work? Driver of motor cycle struck a truck 0019 hrs Natural 1 Yes 2 V No I Director: ed in by the f 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Location (Street and Number or Rural Route Number, City Could not be Suicide (Specify) Major Road / Highway southbound Rockville Pike at Halpine Rd, Rockvi Funeral Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 21, 2006 O.C.M.E. 30. Name and address of person who comp leted cause of death (Item 23a) A10 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Date filed (Month, Day, Year) State APR 27 2006 Registrar

			For State Registrar	State of	Marylan		artment of H		lental Hygie Reg.	- / H H H	5 5 3 3
			Decedent's Name (First, Middle, I	_ast)					2. Date of Death		3. Time of Death
	Physicia /Medic		Margaret	L.	Benne	tt			April 27	, 2006	5:53A M
	Examin		4a. Facility Name (If not institution, g Hillside House					r Location of Death SVILLE		4c. County of Dea Howard	ath
	Funeral Director		5. Social Security Number 6 220-07-3795	Sex 1□M 2☐F	7. Age (In yrs. i	ast birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo JAN 9 ,	9. Bi	rthplace (State or Foreign ountry) aryland
	פ		Usual Residence of Decedent								
	ehow	7	10a, State 10b, County Maryland Howa	ard	1	, Town or Lo Larksv					10d. Inside City Limits
	the M	Director	10e, Street and Number				10f, Zip Code		100	Citizen of What C	
	3a or		5502 Harris Fa	rm Lane			210	29			es of America
36	n 72 hours after deeth with the Maryland "natural", or items 23a or 28e-f ehow salical Examinar must be notitied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	2. (ŽŠtNo e	- 1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Š	2 hou		15. Decedent's	Education		16a. Deced	dent's Usual Occup	pation	160	o. Kind of Business	s/Industry
21215-0036		Completed	(Specify only highest (Secondary (0-12)	College (1	-4or 5+)			during most of work		1 1 0	
	filed within I Hygiene.		12	ndl		Proc	urement		e (First, Middle, Mai		overnment
ano	uid be filed fental Hyg rked other tic event,	Be	17. Father's Name (First, Middle, La Glen W. Benne						Thompson	oen samame)	
Maryland	should nd Me mark mark	မှ	19a. Informant's Name/Relationship	(Type, Print)	_	19b. Mailir	ng Address (Street		al Route Number, C	ity or Town, State,	Zip Code)
Σ	alth a		Wilbur L. Bennet	t - Brot	her	1387	9 Bright	on Dam Ro	ad, Clar	ksville,	MD 21029
Baltimore,	permit. Pages 1 end 2 should be Department of Health and Mental Importent: if item 27 ie marked cent injury or other traumatic event one.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				sition (Name of matory or other pla Memorial		Date 200	. Location - City o	r Town, State
Baltir	Departme Departme mporter any injur		21. Signature of Funeral Service Lice		1	22	2. Name and Addre	ess of Facility Hin	es Rinald	i Funera	1 Home, Inc.
	10200		23a, Party Enter the disease, or co	emplications that ca	used the death						ing, MD 20904 Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final	•			,				Interval Between Onset and Death
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8760	cate be executed physicien and s the burial-transit	dicai E		d							
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.O. Box	The law requires that the death certifi ste has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		irth 2 ∏ Fetai ant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	У		23d. Date of de Month	elivery Day Year
₽.	s that	by Pt	Part II. Other significent condition		ath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
rds	w requires been sign should be		Olgivies Synd	lrome					1 🗆 Yes	2€100 3□F	Probably 4 Unknown
Division of Vital Records,	The law re cate has bee page 2 sho	Completed							24a. Was an autopsy performer	prior to	
Ita	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical	4				26. Place of Deat	h (Check only one)	INO ILLIE	s 2□No
<u>></u>	hysic his ce	ToE	examiner? 1 ☐ Yes 2 ☐ Xio		npatient 2	ER/Outpatier	IL 3 DOA		ome 5 Residenc		ecifyLiving
ouo	nding Ph ath. r: After th e funeral	atlon:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investiga		of Injury h, Day Year)	28b. Time of Injury	Wo	ryat rk? Yes 2 □ No	28d. Describe how	injury occurred	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certifica cumpletely filled in by the funeral director, the funeral director director, the funeral director dire	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Fidue	of Injury - At hong, etc. (Specify	ome, farm, str	reet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funarel Direct completely filled in by	Medical C			sis of examina				and due to the naus red at the time, date		
	o the	Me	29b. Signature and title of certifier				29c. Licens	se number	29d	Date signed (Mor	nth, Day, Year)
)	9		> End(1	eli-	5-		1224	747	Air	PRIL 22.	2006
	U		30. Name and address of person w	no completed caus	e of death (Item	1 23a) (Type,	Print)			10 00	
				ser m	341	- OLA	HO DUODY	LOVET,	SUITE LO	O, OLNEY	2006 m 20832
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 1	2006	egistrar's Signa	ture	ertis			/	
			MUI OT			-/-					

06-03077 Joy Denise Buttrey

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			C	ertificate	of	Death					Reg.	No.	UU	0 10 3
Physicia Medical Exami		1 Decedent's Name Joy Denis	e Butt	rey								Date of I Month May 7,	Da	ay Y	ear	3. Time of Death 0218 hrs
		4a. Facility Name (if 4953 Pintail		n, give street and n	umber)	-	41	b. City, To Frederi		ocation of	Death			4c. County Frederi		
Funeral Director		5. Social Security No. 220-78-256		6. Sex	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min	8. Date o June	,		Foreign	hplace (State or n untry) Maryland
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of 10a. State Maryland 10e. Street and Nur 4953 Pinta 11. Marital Status 1 X Never Marrie 3 Widowed 15. Decedent's Edi Elementary/Secon 17. Father's Name (I Cofferd 19a. Informant's Nar Mary Buttr 20a. Method of Disp 1 XxBurial 2 4 Donation 5 21. Signature of Fun	in the county of	19b. Ma 20b. Place of Discrematory of	Wass If Ye dent's g most	Decedent s, specify Yes 2 Susual Octoor St of working Address 3 Water on (Name ear place)	of Hispacuban, I	Mexican, I specify: n (Give ki DO NOT u Mother's and Numb Coint etery,	nd of wornse retired Name (F Der or Rur. Lane May 20	k done first, Midd Mary fal Route Germ Date 12,	n No-	14. Rac Wh Specify Bb. Kind of E Hu den Surnam r, City or To wn MD 0c. Location ilver S	JSA De-Americ Telephone White Business/Ir Telephone Wn, State, 20874 1 - City or	can Indian, Black, e ndustry esources		
Physician /Medical xaminer	ner	23a. Part I. Enter the failure. List only Immediate Cause (For condition resulting Sequentially list conif any, leading to immediate Enter Under cause Enter Under	ath. Do not ent	500 University Blvd, W, Silver Spont enter the mode of dying, such as cardiac or respiratory arrest and of head							ring, M		Approximate Interval Between Onset and Death			
cecuted and transit	al Examine	(Disease or injury the events resulting in d	at initiated	Due to (or as a		,	7,28a-f,perME,g857,7/25/06 TT									
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S, P.O. I	by P	Part II. Other signifi	cant condition	ons contributing t	o death but no	t resulting in th	ne un	derlying ca	ause giv	en in Part	H.	_		en en		he cause of death?
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tal Rectian: The	Be	25. Was case referre examiner?	ed to medical					26		f Death (C	Check onl	y one)				
F Vid	2	1 V Yes 2	No	Hospital: 1 28a. Date	Inpatient 2	ER/Outpati					Nursing F			sidence 6		Scene
Division of tal or Attending Ples after death. al Director: After led in by the funers	Certification:	27. Manner of Death 1 Natural 2 Accident	Fnd 2:	03	am.	1 Ye	at Work?	No E	subjec	t wa	s shot		ral Route Number City			
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Sertif	3 Suicide 4 X Homicide	detern	not be			arm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) 4953 Pintail Court Frederick, MD						1 Court			
To the Hos within 24 h To the Fun	edical	one) 2/V	Aedical Exam	ysician: To the be niner: On the basis and manner:	of examination			on, in my o	pinion, c	leath occu			ate and	l place, and	due to the	e cause(s)
12		XX	tle of certifler	44	M		O.C.M.E. 29d. Date signed (Month, Day, Year) May 7, 2006									
		 Name and address Susan Hogan 		who completed cau ssistant Me dic			enn	Street	Baltin	nore. M	D 2120)1				
Sta Registr	31. Date filed (Month Day Year) 2006 3 (Registrar's Signature															
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Do

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onald Patrick I	sena	1- For State Registrar Certificate			eg. No. 200	6 1513									
Physici Medical Exami		Decedent's Name (First, Middle, Last) Donald Patrick Behan, III	-	2. Date of Dea Month May 1, 20	Day Year	3. Time of Death 1015 hrs									
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Dea										
		Conway & Howard Streets 5. Social Security Number	Baltimore	la a · · · · · ·											
Funeral Director		100-76-4280 1∑M 2□F 22	If Under 1 Year If Under 24Hr Months Days Hours Min		th(MM/DD/YYYY) 9. B 26/1983 C										
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	_		10d Inside City Limits									
* .	or	MD Anne Arundel	Severna Park			1 Yes 2 No									
Maryl r 28a-f	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cor	untry?									
vith the	eral D	441 Fairford Court 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21146 Was Decedent of Hispanic Origin? (S	Specify Ves or No	USA										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Hearth and Mental Hygiens Department of Hearth is and Mental Hygien do other than "natural", or items 23a or 28a-f she important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Fun		If Yes, specify Cuban, Mexican, Puerto Yes 2K No specify:		White, etc.	rican Indian, Black,									
nours a	eted by	during	dent's Usual Occupation (Give kind of gmost of working life. DO NOT use ref		16b. Kind of Business										
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21215-0036 Uld be filed within 7 Mental Hygiene marked other than	Comple	17. Father's Name (First, Middle, Last)		e (First, Middle, I	Maiden Surname)	College									
2121(uld be fill Mental F marked	Be	Donald Patrick Behan, II			ianne Mains										
e, MD 21 Land 2 should the Health and Meritem 27 is marritraumatic even	To	19a. Informant's Name/Relationship (Type, Print) 19b. Ma Donald Patrick Behan, II/Father	ling Address (Street and Number or												
e, M I and 2 Health item 2		20a. Method of Disposition 20b. Place of Dis	441 Fairford Couposition (Name of cemetery, other place)	Date	20c. Location - City o	D 21146 r Town, State									
More Pages I nent of H ant: If i		, Land 2 Grandian of Removal from State	rans Cemetery M	ay 8, 2006	Crownsvil	le, MD									
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons. P.A. S.P.F.H. 495 Gov. Ritchie Hwy, Severna Park, MD 21146													
Physician		23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate In Between Onse													
/Medical Examiner	111 ()	Immediate Cause (Final disease a <u>Cocaine</u> and narcotic (morphine and fentanyl)) intoxica	iton	Death									
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b													
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after dained. Funeral Director: After this certificate has been signed by the attending physician and lety filled in by the funeral director, page 2 should be detached for use as the burial _transl_	cian/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2	Fetal death 3 Ectopic pregn.	ancy	23d. Date of deliver Month	y Day Y ear									
Box 687 death certific he attending p	/sici	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	Other (Specify)												
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Division tal or Attendir s after death. al Director: A	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, s		28f. Location (S	Street and Number or Ri	ral Route Number, City I Howard Stree									
Diviospital or hours after uneral Diviospital or uneral Diviospital	4 Homicide determined (Specify) found on tracks 29a Certifier 1 Certifying Physician: To the best of my knowledge death or														
Di To the Hospital within 24 hours a To the Funeral i	Medical	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	curred at the time, date and place, and gation, in my opinion, death occurred a	due to the caus at the time, date	e(s) and manner as star and place, and due to the	rted. ne cause(s)									
F×Fŏ	ğ	29b. Signature and title of certifier	29c. License number		29d Date signed (Mo	inth, Day, Year)									
		Theolin M. Hir A mys	O.C.M.E.		May 2, 2006										
		30. Name and address of person who confleted cause of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 I	Penn Street, Baltimore, MD 2	1201											
S	tate	31. Date filed (Month. Day, Year) 32. Pegistrar's Signature													
Regis		MAY 0 9 2006													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1 ten 1 per doc 8855 5-12-06 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Henry Decedent's Name (First, Middle, Last) Frederick Bush 2. Date of Death 3. Time of Death Day Month Year **Physician** 04:49 AM Frederick 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 8. Date of Birth 8/19/1938 Under 24 Hrs Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 67 221-24-5291 Director Delaware Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28e-f ehor the Medical Examiner must be notified at Kent Smyrna Delaware 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 19977 343 Kent Way USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a any njury or other treumatic event, the Medical Examiner must, any plury or other treumatic event, the Medical Examiner must. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★ Yes 2 No
If Yes, Give
Year or Dates: 1958–1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tug Boat Captain Transportation 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Jones Henry S. Bush ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 Kent Way Smyrna, DE 19977 19a. Informant's Name/Relationship (Type, Print) Louise Bush/Wife 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Kent Cremation Service 4/23/2006 Smyrna, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Faries Funeral Directors, Inc. Harl M. Vioneister MO 1375 29 S. Main St. Smyrna, DE 19977 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Day ISCHEMIC STROKE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CARDIOPUL MONARY Examiner Due to (or as a consequence of) anding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed 15CHGMIC Due to (or as a consequence of) Box 68760, Physician/Medical ettending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death P.O. F 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete hes t lirector, page 2 s autopsy performed 2 No 1 ☐ Yes 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 vio atient 2 ER/Outpatient 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) ဥ 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 22 2006 RES-000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North usitest BItimore MO ·Shohe 21297-7106 31. DateUiled (Month 32. F State Registrar

ORIGINAL

			For State Registrer	State of	Marylan		artment tificate			ınd Me		giene Reg. No.	006	15137			
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ith Day	Yeer	3. Time of Death			
	/Medic	al	Carl Jacob Bush								April	25	2006				
	Examin	er	4a. Facility Name (If not institution, give s Lion's Manor	treet and numb	oer)			rown, or berli	Location of	f Death	•		County of Deati				
	Funeral		Social Security Number 6. Sex	7.	Age (In yrs.	last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth	3	llegani	pplace (State or Foreign			
	Director		213-22-2946	M 2□F	79	Yrs.	Months	Days	Hours	Min.	(Month, Day	(Year)	Co	untry) MD			
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	antion										
	Aaryla r sho	ō	PA Bedford											10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	the N	rect	10e. Street and Number			Hyndmar	1 10f. Zip	Code				10a. Citiz	zen of What Co				
	h with	I Di	194 Water Street				1	554	2			•	ISA	,			
036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importents if Item 27 is marked other than "natural", or Iteme 23e or 28e-f show my injury or other treumatic event, the Madical Exaction mat be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? No	1	Was Decedon f Yes, speci I ☐ Yes 2	rty Cubar	spanic Orig n, Mexican, Specify:	jin? (Spec Puerto R	ify Yes or No- ican, etc.)	1	14. Race - Amer Black, White				
у О	72 hc	etec	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	kind of won	k done d	urina most	of working	9	16b. Kir	nd of Business/l	ndustry			
121	within the.	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	DO NOT us	e retired)					Thu	cking			
D	filed v Hygie ther t	Co	17. Father's Name (First, Middle, Last)	<u> </u>		Inuc	.k Dri	ver.	18. Mother	r's Name	(First, Middle,	Maiden :		Clocky			
an	ld be ental ked o	To Be	Charles E. Bush S								Turne						
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Typ						nd Number	r or Rural	Route Numbe	nber, City or Town, State, Zip Code)					
Σ,	and 2 selth an 27 i		Lois I. Bush/ Wife								A 1554	5					
Baltimore, Maryland 21215-0036	ages 1 int of He t: If iter y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hyndman Cemetery 4-29-20										20c. Location - City or Town, State				
薑	artme corten injur		21. Signature of Funeral Service License	p / l			. Name and				-2006	ну	ndman,	PA			
ñ	Departition Department of the sany in the		Suomus 11.	tute	ス ノ	10	Harve	y H.	Zeig	ler	Funeral	2 Hor	ne. Hund	dman, PA			
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	gned t	by P	Part II. Other significant conditions cont			ulting in the un	iderlying ca	use give	n in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?			
ğ	w require been sli should k	ted	Diabetes My	LLITA	7						1 □ Y	9S 2	¶o 3∏Pro	bably 4 □Unknown			
Vital Records,	law ras be	Completed	Dementin								24a. Was a		24b. Were aut	opsy findings available ompletion of cause of			
E H	ilclan: The lav certificete has rector, page 2	Col									perform 1 Yes	ned? 200 No	death? 1 🗌 Yes	2 No			
<u> </u>	sician certifi rector	Be o	25. Was case referred to medical examiner?	ospital:				Othe			Check only on						
ō	Physer this eral d	n: To	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of		lc. Injury Work	Nur		e 5 ☐ Reside d. Describe ho		Other (Speci	f(y)			
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Division of	or Atta	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	Injury - At ho , etc. (Specify	ome, farm, stre	et, factory,	office		28	f. Location (St City or Town		Number or Rui	al Route Number,			
	To the Hoepital or Attanding Physician: The law requires that the death certif within 24 hours atter death, within 24 hours atter death. To the Funeral Director: Aller this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		200 Contillor Date of the control							- 1							
	Hoel 24 ho Fune stely f	Medicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	er: On the basi and manne	is of examinal	wledge, death tion and/or inv	occurred a estigation, i	t the time in my opi	e, date and nion, death	place, an occurred	d due to the call at the time, d	ause(s) a ate and p	and manner as : place, and due i	stated. to the cause(s)			
	To the Hoepital within 24 hours To the Funerel completely filled	Me	29b. Signature and title of certifier	///	J. 100.		29c.	License	number		2	9d. Date	signed (Month,	Day, Year)			
	/		1	Jall-			7	ロロフ	054	1	1	Ty.	: 8 26	, 2005			
	(ټ		30. Name and address of person who con	npleted cause	of death (Item	1 23a) (Type, F	Print)	74	ور ر	507	90.	J. Co					
_	MAS		Dr. Gregg Dunak	dscop	912 5	beton	Dr	ive	; Cu	mb	erland	d, r	nD o	21502			
	Sta Registr		31. Date filed (ModPRY, 2008 2001	32/97/9	istrar's Signa	S A	ES.					,					

	1	For	epartment of Health and Certificate of Death	Reg. No.	006 15 38
Physici /Medio Examir	an al	1. Decedent's Name (First, Middle, Last) Beverly Anne Blank 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital	4b. City, Town, or Location of Dea		Year CE C726 M Thy of Death (EGaNY
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		s. 8. Date of Birth	9. Birthplace (State or Foreign Country) Maryland
he Maryland :8a-f ehow cillied at	Director	10a. State 10b. County 10c. City, Town Maryland Allegany Mount Sa		10g Citizan	10d. Inside City Limits 1 XYes 2 □ No of What Country?
Baltimore, Maryland ZIZI3-UU30 permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or itame 23a or 28a-1 ehow any injury or other traumatic event, tra Modical Examinar mast be notified at once.	by Funerai	10e. Street and Number 14028 Mount Savage Road, N.W. 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	21545- 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	U.S.A.	ace · American Indian, lack, White, etc.
2 12 13-0030 iled within 72 hours afi tygiene. ther then "neturel", or nt, the Modical Exerti	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) TETATY 18. Mother's N	rorking	Business/Industry health dept.
Maryland of 2 should be file th and Mental Hy 27 is marked oth	To Be	Carl Field 19a. Informant's Name/Relationship (Type, Print) 19b.	Elnora C	Greene Rural Roule Number, City or Tow	vn, State, Zip Code)
Baltimore, M permit. Peges 1 and 2 Depertment of Health is important: if item 27 i eny injury or other tre pnce.		20a. Method of Disposition 1 Paurial 2 Cremation 3 Removal from State	Report NW (Name of crematory or other place)	Ount Savage Mary Date 20c. Location i-May-2006 Mt. Savage	n - City or Town, State
Dermit. P Depertme Importan eny injur.		21. Signature of Funeral Service Licenses John Murth 23a. Pan. Enter the disease, or complications that caused the death. Do n	22. Name and Address of Facility Durst Funeral Home, 57	Frost Ave., Frostburg	
by bright and the bri	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the conditions of the con		action	Interval Between Onset and Death
F.C. BOX 00 net the death certificat d by the ettending phy letached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown Unkno	3 □Ectopic pregnancy 5 □ Other (specify)		Date of delivery Month Day Year
	Completed by Pr	Part II Other significant conditions conducting to death but not resulting in Classic Port My gran will	the underlying cause given in Part I.	1 ☐ Yes 2 No	Were autopsy findings available prior to completion of cause of
OI VICAL F Physician: Th this certificate ral director, pag	To Be		Othors	performed? 1 Yes 2 No Death (Check only one) 3 Home 5 Residence 6 2 28d. Describe how injury oc	
DIVISION of all or Attending F after death. I Director: After d in by the funeral or an arms.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, lai building, etc. (Specify)	M 1 Yes 2 No	281. Location (Street and Nu City or Town, State)	imber or Rural Route Number,
To the Hospital or Atte within 24 hours after de within 24 hours after de completely filled in by it	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier			ne, and due to the cause(s)
71 25	ate	30. Name and address of person who completed cause of death (Item 23a) 31. Date liled (Month, Day, Year) MAY 0 3 2006	Type grint) 925 Bishop	Wedsh Ar, En	nherland, MD

				For State Registrer	State of Maryland		rtment of Hea tificate of De			ene 006	15139
				Decedent's Name (First, Middle, Last)				2	. Date of Death	1	3. Time of Death
		Physici /Medic		Agatha	Eilee	en	Bean	Δ	Month	23, 2006	04:20 AM
		Examin	er	4a. Facility Name (If not institution, give stre			4b. City, Town, or Loc			4c. County of Death	
				Lions Manor Nursin			Cumber 1 a		Data of Blats	Allegany	
		Funeral		5. Social Security Number 6. Sex 1 □ N	7. Age (In yrs. II	Yrs.		lours Min.	Date of Birth (Month, Day,	_ }	lace (State or Foreign
		Director		Usual Residence of Decedent	73				7/12/19	932 Mary	land
		land ow		10a. State 10b. County	10c. City	, Town or Lo	ation				0d. Inside City Limits
		Man	to	MD Alleg	anv		Cumbe	erland			1 ☐ Yes 2 ☐ No
		r 28s	Director	10e. Street and Number			10f. Zip Code	0 2 2 4 11 0	10	g. Citizen of What Cour	ntry?
		h wit	a D	14101 Winchest	er Road		21502	2		USA	
		dea	Funeral		. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of Hispa Yes, specify Cuban, N	nic Origin? (Specif Nexican, Puerto Ric	y Yes or No-	14. Race - Americ Black, White,	
	9	or its	正	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give			pecify:		Specify:	
نيا	8	ural',	d by	3	Year or Dates:					W	hite
للا	5	"nat	Completed	15. Decedent's Educa (Specify onfy highest grade of		16a. Deced	ent's Usual Occupation kind of work done durin OO NOT use retired)	n ng most of working	1	6b. Kind of Business/In	dustry
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7	D 2	filed Hygir ther	ပို	17. Father's Name (First, Middle, Last)			Homemake 18.	: I . Mother's Name (f	First, Middle, M	Home (aiden Surname)	
7	an	d be ental ced o	To Be	Emil	Haselbe	roer		Goldie		O'Ne	a 1
Agatha	Ž	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show reumatic event, the Medical Evantian must be inclified at	-	19a. Informant's Name/Relationship (Type			g Address (Street and		Route Number,	City or Town, State, Zip	
1	Ž	nd 2 alith a 27 is r trau		Donna Kifer / daugh	nter	P.O.	Box 63,	Lowber, P	A 1566	0	
Bean,	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examination in the Incillied at 2006.		20a. Method of Disposition	C	ace of Dispos	sition (Name of pace)	Date	9 2	0c. Location - City or To	own, State
Ö	Ë	Page nent c nt: If		1 N Burial 2 ☐ Cremation 3 ☐ Ren `4 ☐ Donation 5 ☐ Other (Specify)	noval from State	-		ns 04/26	/2006	LaVale, M	D
S.	alti	permit. Departrimporta any inju		21. Signature 1 Fyneral Service Licensee	1 4	22	Name and Address of	Facility Ada	ms Fami	ly Funeral	Home, P.A.
ת	Ω	88 5 8		Kolet C. X	Clan)	40	4 Decatur	Street,	Cumberl	land, MD 2	1502
				23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that carsed the death	. Do not ente	er the mode of dying, s	uch as cardiac or r	espiratory arre	st,	Approximate Interval Between
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		/Medical		resulting in death)	Due to (or as a consequ		0,7,			3	
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		Si ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):					
		and I-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):		· · · · · · · · · · · · · · · · · · ·			
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		eath certifi attending I for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna					23d. Date of delive	эгу
	ğ	death a atte	iciai	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
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	>	hysic nis ce I direc	To	1 ☐ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatien		4 Nursing Home	5 Resider	nce 6 □Other (Specif	y)
	0	ding PI h. After th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe hov	w injury occurred	:
	Sio	death. ctor: A y the fu	cati	2 Accident investigation				2 No			
	Division of Vital Records, P.O. Box	or Attend after death Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str /)	eet, factory, office	28	f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,
		the Hospitel or Attending Physicien: The law requires that the death certifun 24 hours after death, the this certificate has been signed by the attending the Funeral Director: After this certificate has been signed by the attending pletely filled in by the funeral director, page 2 should be detached for use a	Ce	20a Cartifier (Department Phone	rian: To the best of	wlodes de	accurred at the time	data and place as	d duo to the	uso(s) and masses	totod
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		To the Hospitel within 24 hours a To the Funeral C completely filled	Me	29b. Signature and title of certifier			29c. License nu	ımber	29	d. Date signed (Month,	Day, Year)
		.)		> Huch	·		D7100	TOP	A	PRIL 24, 2	006
		6,3		30. Name and address of person who com		23a) (Type,	Print)	,		1 ~	
	_			Dr. Harjit Sidhi	1 925 Bish	10P V	Jalsh Koo	id Cum	berla	nd,mD	21502
		Sta		31. Date liled (Moritin, Day, Year)	32. Registrar's Signa	ture	land.	,			que de la constante de la cons
5		Regist	al	APR 2 5 200	10 Kantons	11.	SOBAGE!				

		1	For State Registrar	State of Marylar		artment of F		and Men		iene _{og. No} 20	06	15140
	Dharaini		1. Decedent's Name (First, Middle, Last,		-	_			Date of Deat Month		Year	3. Time of Death
	Physici: /Medic	al	NORWOOD BARNA						RIL 2	9 2006		11:04 A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		of Death		4c. County o		
			MEMORIAL HOSPI 5. Social Security Number 6. Securi		last birthday)	CUMBER If Under 1 Year			Date of Birth	ALLEG	9. Birthpla	ce (State or Foreign
	Funeral Director			M 2□F 71	Yrs.	Months Days	Hours	Min. NC	Month, Day,	1934	MAR	YLAND
	D.		Usual Residence of Decedent	10c Ci	ly, Town or Lo	ocation					100	d. Inside City Limits
	laryla shov	5	MD ALLEGA		UMBERL						100	1 □ Yes 2√XNo
	the N	rect	10e. Street and Number			10f. Zip Code			1	0g. Citizen of W	hat Countr	y?
	3a or	٥	11901 KNOB ROAD,	N.E.		21502				U.S.A		
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. dother then "natural", or items 23a or 28a-f show event, I're Medical Exartinar must be ricitited at	by Funeral Director	11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 154-		Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 🗓 No	an, Mexican	n, Puerto Rica	Yes or No- n, etc.)		America , White, et	c.
20	72 ho	eted	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup	during most	t of working		16b. Kind of Bus	siness/Indu	istry
7	ithin ben ben	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	•	ΔT.	Δ	LLEGHEN	Y POW	ER CO.
N	filed w Hygier Sther ti		12 17. Father's Name (First, Middle, Last)		LIKSI	CLIADO D.	,			Maiden Sumame		
	should be filed withir nd Mental Hygiene. marked other then imatic event, Ita Mi	To Be	ERNEST BARNES					BEL MAI				
Maryland	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: if Item 27 is marked sny injury or other traumatic events.		19a, Informant's Name/Relationship (T)			ng Address (Street 1 KNOB R						ode) .502
e,	1 and Heelth em 27 ther t		MARY DAVIS BARNES 20a. Method of Disposition			osition (Name of	OMD / I	Date	-	20c. Location - (
nor	ages nt of 1 t: # ite		1 ☐ Burial 2 🛣 Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or other pla		15/04/3	5.1	CUMBI	•	
Baltimore,	artme ortani injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	-/		2. Name and Addre UPCHURCH	-					
Ba	Depa Impo any i		Unerd A	topocherch		UPCHURCH 202 GREE	FUNE NE STE	RAL HOI REET, (CUMBER	RLAND, M	D 21	.502
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the dea ne cause on each line. a. <u>LUNG CANCEF</u> Due to (or as a consec	2	ter the mode of dyli	ng, such as	cardiac or re	spiratory arr	est,	{	Approximate Interval Between Onset and Death EARS
68760,	ate be executed hysicien end the burial-transit	Ical Examiner	tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect Due to (or as a consect d.	C. Darenton							
O. Box	death certific e ettending p ed for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnanc □ Other (specify)	y			23d. Date Mon	of deliver	y Day Year
s, P	gned be de	۵	Part II. Other significant conditions co	ntributing to death but not re	sulting in the (underlying cause gr	ven in Part I.		23e. Did to	_		cause of death?
I Record	The ete h page	Completed	97330 1033 1100 1200 1						24a. Was a autops perform 1 ☐ Yes	med? d	rior to com eath?	sy findings available pletion of cause of
Vital	Physicien: Th this certificete rai director, pag	Be	25. Was case referred to medical examiner?	Hospital:	7	· · Ot	her	e of Death (C			10	
ō		. To	1 Yes 2 17 No 27. Manny of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time (III 3LI DOA	4 🗆 140			ence 6 Other		
on	Attending r death. ector: After by the funer	atlor	1 V atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork?]Yes 2∐	No				
Division	2 = -	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, si	reet, factory, office		28f.	Location (S City or Town	treet and Numbern, State)	er or Rural	Route Number,
ū	urs ere	Medical Ce		vsician: To the best of my kn iner: On the basis of examin and manner stated.								
	To the Hos within 24 ho To the Func completely f	Me	29b. Signature and title of certifier	······································	(se number	9	2	29d. Date signed	(Month, D	Day, Year)
(γ		Deveron	Calker	- y	D.	544	//		APRIL	29	2006
1	TIVA		30. Name and address of person who o	completed cause of death (Ite	m 23a) (Type	. Print)				20 10 10		
	1116		DR. BEVERLY CALKIN	IS, 500 MEMOR		E., SUITE	105,	CUMBE	RLAND,	MO	21502	
	Sta Regist		31. Date filed (Month, Pay, Year)	006 Marie Sign		Cocke						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dale of Death 1. Decedent's Name (First, Middle, Last) Physician April 2006 0734 AM HERBERT LAWRENCE BURKHOLZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 (XM 2 ☐ F Yrs. 103-22-0661 Director 76 NEW YORK Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND BOONSBORO WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 238 21713 4 DELLA LANE U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 55 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Š 3 Widowed 4 □ Divorced "naturel", WHITE leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compl other than Elementary/Secondary (0-12) College (1-4or 5+) WRITING AUTHOR & JOURNALIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fil ment of Health and Mental H lent; If item 27 le marked ot 27 le marked or treumatic even SIDNEY BURKHOLZ EVA MARGOLINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HOWARD BURKHOLZ/SON 735 SW 148th AVE, #1713, DAVIE, FLORIDA 33325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 □ Burial 2 1 Cremation 3 □ Removal from State permit. Page Department of Importent: If eny Injury or once. 4 Donation 5 Other (Specify SMITHSBURG CREMATORY | 05/01/2006 | SMITHSBURG, MARYLAND 21. Signatu a of Fund 7606 Old National Pike BAST FUNERAL HOME Paul m. Dean Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, occomshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final MeTasTaTIC Squamous Cell **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached for Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed ral director, page 2 should be del 23e. Did tobacco use contribute to the use of death? Completed by HyperthyroidISW 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No pertensian 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of death?
 The Yes 2 No NICOTINE BRUSE 1 Yes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 N 2 ☐ ER/Outpatient 3 ☐ DOA Division of 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after ò within 24 hours a To the Funeral I 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) å 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Frances Co Dure and 4006117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15H-20 Prili 51 MG NUO MD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			1 - For State Registrar	. 10000			and / Dep		t of H	ealth a		lental Hygi	_	06	15142
	Physic /Medi		1. Decedent's Name (F	irst, <i>Middl</i> e, Last) ames Be	rnar	delli						2. Date of Death Month	Day	Year 2006	3. Time of Death 5:45 A M
1	Exami		4a. Facility Name (If no	gton Co	unty		ital			Location of			4c. County Wash		on County
	Funeral Director		5. Social Security Number 092-14-32	72 ¹ X	M 2□F		rs. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, July 28	Year) 1922	9. Birthpl Count Penn	ace (State or Foreign ry) sylvania
	Maryland f show	Į.	Usual Residence of De 10a. State 10 Maryland	b. County Washing	rton	10c.	City, Town or Lo	Hage:	rsto	 λ7Ω				10	od. Inside City Limits
	3a or 28a-	Il Direct	10e. Street and Numbe					10f. Zip	Code	21740		10	g. Citizen of W	hat Count	ry?
9036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23a or 28a-f show important: If Item 27 is marked other than "natural", or Itame 23a or 28a-f show almostrant in Item Medical Exercides must be neithed at 2005.	Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 Married	Armed F	2 □ No1 ().	-12-42	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)		e - America k, White, e	itc.
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	jes 1 and 2 sho of Heelth and if Item 27 is m or other traum		Mae Fink 20a. Method of Disposit 1 ☑ Burial 2 □ C	Bernard	lelli	20b		9 Vern	nont	Ave.	Hage	Prestown 2		nd 21	740
Baltimore,	permit. Peges Depertment of Important: If it any injury or o		4 Donation 5 C	Other (Specify)				2. Name and	d Addres	s of Facility	Do	uglas A.	Fiery	Fune	Maryland ral Home land 21742
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ion of	Ilng After fune	ıtion; To	1 Yes 2 No 27. Mapner of Peath 1 Natural 5 2 Accident	Pending investigation	28a. Date		28b. Time o		Bc. Injury Work	4 🗀 19u13	2	ne 5 Resider 8d. Describe hov			
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	with Con	2	29b. Signature and title		in it).			Z3°				Date signed		
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100		_1	State Registrar			Cei	rtificate	e or l	Death		2 Date of Dea	Reg. No.	_ بالل	3. Time of	Doath
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	/Medic	al -	Lorna Jean Bow 4a. Facility Name (If not institution,		horl		4h City	Town or	r Location of		April		unty of Death	10	
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	Funeral			S. Sex	7. Age (In yrs. I	last birthday)	If Under	1 Year	If Under Hours		8. Date of Birt (Month, Da	th v Year)	9. Birth	place (State o	r Foreign
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	the N	ect	10e. Street and Number	191011			10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
	with Sa or		112 South Artiza	an Street				2179	95			US	A		
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89	tificati ig phy as the														
Вох	eath certifii attending p	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out 1⊟Live b	come of pregnation		□Ectopic p	regnanc	у			230	d. Date of deli-		Year
Э. В	ie deal the att hed fo	sicle	in the past 12 months? 1 Yes 2 No	4□Pregn 9□Unkno	ant at time of o	death 5	Other (s)	pecify) _						,	
P.O.	that the de ad by the detached	Phy	9 Unknown Part II. Other significant condition	ins contributing to de	eath but not res	sulting in the	underlying	cause or	ven in Part	l.	23e. Did	tobacco use	contribute to	the cause of	death?
ds,	ires tha signed d be de	Completed by Physiclan/Med	Tarrii. Othor organization			.	, , ,				1 🗆	Yes 2 🗹	No 3□Pro	babiy 4 🗆	Unknown
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sio	death. ctor: A y the fu	cati	2 ☐ Accident investig	gation			M		Yes 2		28f Location	(Street and I	Vumber or Ru	ral Route Nun	nber
Division of Vital Records,	or At after d Direct in by	Certification: To	4 Homicide determ	inad 200, Flace	of Injury - At h ing, etc. (Speci		street, lactor	у, опсе		1	City or To	wn, State)	74		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifyin	g Physician: To the	best of my kn	owledge, dea	ath occurred	at the t	ime, date a	and place, a	and due to the	e cause(s) ar	nd manner as	stated.	
	P To Hoo	Medicai	(Check only 2 Medical one)	Examiner: On the b and man	asis of examin ner stated.	ation and/or	investigatio	n, in my	opinion, de	eath occurre	ed at the time	, date and p	lace, and due	to the cause(3)
	within 2 To the compler	ž	29b. Signature and title of certifie	1 0			29	c. Licen	se number	r		29d. Date :	signed (Monti	n, Day, Year)	
			Muchael	of hu	laure	k M	0	0	416	67		7	. 67.	06	
^	2 -		30. Name and address of person	TA .		am 23a) (Type	e, Print)	,1.	. 1	1.	A	12		. 1	0
PF	23	nto-	31. Date filed (Month, Day, Year)	M (OrA	CCC Gigistrar's Sign	illic nature	1	cn (CU1	can	n U J	ivas	e/1/00	n Iri	/.
3	Regist	ate rar	31. Date filed (Month, Day, Year)	1 2006	College	1. 16	parke	/					signed (Month		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04 **Physician** 26 Buckley 2006 9:30a M Margarette J. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** North Pines Care Home Manchester Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 213-50-0852 Yrs. 08-30-1908 Director OK Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exaction must be notified at 1 ☐ Yes 2 ☑ No Director MD Prince Georges Riverdale 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4714 Sharidan Street 20737 USA death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 15. Oecedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fite Department of Heath and Mental Hy Important: if Item 27 is marked other propriate or other traumatic event, 17. Father's Name (First, Middle, Last) Be Winfield Scott Etta Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark A. Buckley - Son P.O. Box 4340 Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 04-28-06 Hampstead, MD 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licerus e tuble MO0550 934 S. Main St., Hampstead, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the difease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner igned by the attending physicien and be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a conse quence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Clinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has 2 NO 1 ☐ Yes To the Hospital or Attending Physician: : After this certification : 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 her (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending 1 Yes 2 No after death. investigation 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie -0054218 malcalus dune, Westminster MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 8 2006

32. Refistrar's Signature

		1 - For State Registrar	State	of Maryl	and / Dep	oartment e <i>rtificate</i>	of H	ealth a Death	and Mo		giene 2 (006	15145
B1		1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
Physicia /Medic		Mary Yvonne	Brooks							April	26, 20	06	9:58 a M
Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, 1	Fown, or	Location of	of Death		4c. Count	y of Death	
		Holy Cross Hos						Sprin				ontgo	
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In)	yrs. last birthda OF Yrs.	Months	1 Year Days	If Under Hours	Min.	Date of Bird (Month, Da	y, Year)	9. Birth	place (State or Foreign ntry)
Director		206-10-8831 Usual Residence of Decedent			85 Yrs.				1	May 28,	1920	Pen	nsylvania
land ow		10a. State 10b. County		10c.	City, Town or	Location							10d. Inside City Limits
Marylan -f show	ţ	Maryland Mon	tgomery		ī	(ensind	rt on						1 ☐ Yes 2 ☐ No
r 28a	Director	10e. Street and Number	egomery			10f. Zip					10g. Citizen of	What Cou	ntry?
h witi 23a o st tre		10817 Melvin	Grove Co	urt		208	395				U:	SA	
deat	Funerai	11. Marital Status	12. Was De Armed F	cedent Ever i	in U.S. 13	. Was Deced	ent of His	spanic Ori	gin? (Spec	cify Yes or No	- 14. Ra	ce - Ameri	
after or its	Ē	1 Never Married 2 Marr		2 XNo		1 ☐ Yes 2		Specify:		nicari, etc.)	1	ack, White, MB1ac1	
ral',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:				Spoony.			Зресі	yDI aci	<u> </u>
72 h natu	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	(Giv	edent's Usual re kind of work DO NOT use	k done d	uring most	t of workin	g	16b. Kind of B	Business/In	dustry
withir Iban	E D	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		eacher	,				Tr. A.		
itied within 72 hours after death with the Maryland Hygiene. Hygiene, sthen "natural", or items 23s or 28s-f showent, the Madical Examinar must be notified at		17. Father's Name (First, Middle,				eacher	_	18. Mothe	ar's Name	(First Middle	Maiden Suma	ıcatio	on
d be ontal) Be	David McKeever								Jnknown			
should Me	ဥ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Ma	ilina Address	(Street a				er, City or Town	n. State. Zic	Code)
and 2 string and 2		Alicia Armstro	na/ Daua	htor	1091	7 Mol.		*******	Com	. Van		her.	20005
the and		20a. Method of Disposition	mg/ baug		b. Place of Dis	position (Nam	e of	HOVE	Anri	27,	singtor 20c. Location	- City or To	own, State
and and and and and and and and and and		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S		I State	etropolit			1	200		Alexand	dria.	Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Manual Hygiens. The filem 23s or 28s-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.	li	21. Signature of Juneral Service		1		22. Name and	Addres	s of Facilit	<u>Y</u>		Home		g
Departing Departing Departing Per in poor in p		RobertEN	Camel	7	5	00 Uni	vers	sity	Blvd,	W, Si	lver Sp	ınç oring,	MD 20901
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deach line.	death. Do not e	nter the mode	of dying	, such as	cardiac or	respiratory a	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			ndrome								Onset and Death
/Medical		resulting in death)			sequence of):								
Examiner		Sequentially list conditions,	b		ract In	fectio	n						
D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a son	eaquanea of):								
and and	хаш	that initiated events resulting in death) Last	c. Due to	(or as a con	sequence of):							-	
ate be executed hysicien and the burial-transit				(01 43 4 0011	sequence or,								
# \$ # 6	dical		d										
leath certifice ettending ph	/Me	IF FEMALE:	23c. If yes, o	utcome of pre	egnancy						234 D	ate of delive	en/
etter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 1		☐Ectopic pre					1	onth	Day Year
by the darected	hysician/Me	9 Unknown	9□ Unk	nown									
res that igned be det	by P	Part II. Other significant condition	ons contributing to	death but not	resulting in the	underlying ca	use give	n in Part I.		23e. Did to	obacco use cor	tribute to t	he cause of death?
3 -E 07 D		End-Stage Renal	Disease	, Diab	etes Me	llitus	, Ну	perte	ensio	n, 101	∕es 2 ₄ ⊡No	3 🗆 Prot	oably 4 Unknown
aw requ	Completed	Atherosclerotic	Cardiov	ascula	r Disea	se, Ma	lnut	ritio	on	24a. Was		Were auto	psy findings available
Physician: The laver this certificete hes rail director, page 2	ē		•							autor perfo 1 ☐ Yes	rmad?	death?	mpletion of cause of
stan: artific ctor,	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
hysic his co	၉	1X Yes 2 □ No			2 StEP/Outpati		A Othe	^C 4 □ Nu	irsing Hom	e 5 Resid	dence 6 □Ot	her (Specif	(y)
ing P		27. Manner of Death 1. Natural 5 ☐ Pendin	28a. Date (Mo	e of Injury onth, Day Yea	r) 28b. Time Injury		Bc. Injury Work			8d. Describe l	now injury occu	rred	
tend leeth tor: /	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be		1	М		′es 2 🗆 I		0()			18
or A after Direction by	Certification:	4 ☐ Homicide determ	nined 288. Place	ding, etc. (Sp	At home, farm, : ecify)	street, factory,	office		2	City or Tox	vn, State)	per or Hura	al Route Number,
poltal curs cours coral filled		29a. Certifier XXCertifyin	ng Physician: To th	ne hest of my	knowledge de	ath occurred a	it the tim	e date an	d place, a	nd due to the	cause(s) and m	20001 200	tated
to the Hospital or Attanding Physician: within 24 hours after deeth; of the Funeral Director: After this certific ompletely filled in by the funeral director,	edicai	(Check only 2 Medical one)	Examiner: On the	basis of exam	nination and/or	investigation,	in my op	inion, dea	th occurre	d at the time,	date and place	, and due to	the cause(s)
To the Hospital or Attanding Ph within 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral	Me	29b. Signature and title of certifie	r ^	1		29c.	License	number			29d. Date sign	ed (Month,	Day, Year)
10		> K. Lenou	sunom	nea	1		D533	67			April	26, 2	006
10		30. Name and address of person	who completed car	use of death ((Item 23a) (Typ	e, Print)							
		Shyamsundar Ra	jan, M.D	. 34:	ll Olan	dwood	Cour	t, #]	105,	Olney,	MD 208	32	
Sta Registr		31. Date filed (Month, Day, Year) APR 2 8	2006	Registrar's S	ignature	radio							

		1	1 - For State Registrar	State of Marylar		irtment of H tificate of I			giene Reg. No. 200	6 15146
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Alfred Max	Breitkop	of				18,2006	5:50P ^M
	Examin		4e. Fecility Name (If not institution, give s				Location of Death		4c. County of	Georges
			Southern Marylai			Clintor	If Under 24 Hrs.	8. Date of Birth		
	Funeral		5. Social Security Number 6. Sex	M 2□F 66		Months Days	Hours Min.	April 24	/, Year) // 1939	B. Birthplece (State or Foreign Country) Germany
	Director	-	265-64-7827 Usual Residence of Decedent	00				MPIII 2-	7,1000	Germany
-	iow F		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
2	Man Fireh	ţ	MD Charles		Brandy	wine				1 □XYes 2 □ No
-	or 284	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	oealn with the maryland ms 23a or 28a-f show	a	17231 Creekside	Drive		206			USA	
	be filed within 72 hours after death with the marylar half Hygiene. Ad other than "natural", or items 23a or 28a-1 show event, the Medical Examinur must be multiled at	by Funeral Director	11. Marital Status 1 Never Married 27 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: 19		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛛 No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	pecify Yes or No- p Rican, etc.)	Specify:	American Indian, White, etc. White
ברים הרים	atura stura		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busi	ness/Industry
0	Wadh	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	kind of work done of DO NOT use retired	during most of world)	king		
7 7	yiene giene	E O	Elementary/Secondary (0.12)	5+	Arc	hitect			Archite	
_	be filed stal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
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Mar	2 should be and Mental is marked (19a. Informant's Name/Relationship (Ty			ng Address (Street				
≥ .	and sealth m 27			reitkopf(wife		31 Creek		Date	20c. Location - C	
altimore,	Or H Is		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F			sition (Name of matory or other place				
E .	tant:	١.,	`4 ☐ Donation 5 ☐ Other (Specify)	į IV		IITanCrem Name and Addre				dria, Virginia
Rai	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licens	A Cos	to 1	205 Belle	Haven R	oad Alex	xandria,	Virginia22307
4.			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the de- ne cause on each line.	ath. Do not en	er the mode of dyin	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Death
0.1	nysician		Immediate Cause (Final disease or condition	CARDIAC	CARR	YTHMIA				Ondor and Dodan
	/Medical		resulting in death)	Due to (or as a conse	equence of):					
	Examiner	Ш	Sequentially list conditions,	CORONAR		ERY DIS	EASE			
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consc	acineura ou					
	ecute and trans	каш	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8760,	cate be executed physician and the burial-transit				, ,					
87	phys the	dicai								
9 X	law requires that the death certificate be executed as been signed by the attending physician and s should be detached for use as the burial-transif	/Me	IF FEMALE:	3c. If yes, outcome of preg					23d. Date	of delivery
Вох	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Dectopic pregnancy Other (specify)	У		Mont	h Day Year
o.	that the de led by the a detached f	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown						
صِّ	res that igned b be deta	by Pt	Part II. Other significant conditions co	ntributing to death but not re	esulting in the o	inderlying cause giv	ven in Part I.	23e. Did te	obacco use contrib	oute to the cause of death?
g	quires n sign							10	Yes 2 ☐ No 3	Probably 4 XUnknown
Ö	tw require s been sig should b	Completed	1					24a. Was	an 24b. W	ere autopsy findings available or to completion of cause of
8	0 - 0	E						perfo	ırmed? de	ath? ☐Yes 2☐ No
ta	ilcien: Th certificate rector. pag	(a)	25. Was case referred to medical				26. Place of Dea	ath (Check only o		
>	S D	To B	examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	EP /Outpatie	nt 3 DOA	ner: 4 Nursing H	lome 5 ☐ Resid	dence 6 Other	(Specify)
0	ding Phy n. After thi funeral		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju Wo	ry at rk?	28d. Describe I	how injury occurre	d
<u>Ö</u>	Attending r death.	atic	2 Accident investigation		1	M 1	Yes 2 □ No			
Division of Vital Records,	al or Attendate after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe		reet, factory, office		28f. Location (3 City or Tox		r or Rural Route Number,
	To the Hospital or Attending Phyminic 24 hours after death. To tha Funerel Director: After the completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my k iner: On the basis of exami and manner stated.	knowledge, dea ination and/or in	th occurred at the transfer of	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the within 2 To the complet	₩ We	29b. Signature and title of partifier			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
)	H 3 H 0			RICO		# D	41580		04/27/	2006
	12		30. Name and address of per on who co	omple ed cause of death (II	tem 23a) (Type	, Print)			5 17 27 1	
	-			elso,MD 7503			Clinton,	Maryla	nd 20735	
	St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		barle				

			1 - For State Registrar	,430	State o				artmer	nt of H			•	Hygie	ene 1. No.2	06	15147
- 4	Physicia	· [8]	1. Decedent's Name (First, Mi	ddle, Last)								2. Date of	1	Day	Year	3. Time of Death
	/Medic	al	Fasuluku		Amadu		Bay	oh					Apri	1 23	, 200		5:30A M
	Examin	er	4a. Facility Name (If not institu				1				Location of	of Death				ty of Dea	
			Montgomery 6 5. Social Security Number					st birthday)	Oln	r 1 Year	If Under	24 Hrs.	8. Date of	of Birth		ntgo	
***	Funeral Director		557-04-4519 Usual Residence of Decedent	1[X M 2□F	7. Ago (1	56	Yrs.	Months		Hours	Min.	DEC.	12,	1949	Si	thplace (State or Foreign ountry) erra Leone
	yland		10a. State 10b. Cou	nty		1	0c. City,	Town or Lo	ocation								10d. Inside City Limits
	a-fal	ctor	Maryland Mont	gome	ry]	Montg	omery	Vil	lage						1 X Yes 2 No
	or 28	Olre	10e. Street and Number						10f. Zi	p Code				100	g. Citizen o	f What Co	ountry?
	ath w	rai	8726 Delcris	Dri						2088							s of America
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow important: it item 27 is marked other than "natural", or items 20 and 20	Completed by Funeral Director	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Divor		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 XNo ve	er in U.S				ispanic Ori an, Mexican Specify:		ecify Yes o Rican, etc	or No- c.)		ack, Whit	erican Indian, te, etc. Black
Õ	natur	ted	15. Dece (Specify only hig					16a. Dece	dent's Usu	al Occup	ation	t of works	20	16	Sb. Kind of	Business	/Industry
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2	ed wi ygien ygien yer th				5			Civ	il En	gine			· · · · · ·				vernment
Maryland 21215-0036	ould be fil Mental H arked oth	To Be	17. Father's Name (First, Mide Abu Bayoh	lle, Last)									Fasu		iden Sum	am <i>e)</i>	
lar	2 shd and is m	W.	19a. Informant's Name/Relati	onship (T)	rpe, Print)			19b. Maili	ng Addres	s (Street	and Numbe	er or Rura	Il Route N	lumber, (City or Tow	n, State, .	Zip Code)
nore, I	ages 1 and nt of Health t: If item 27		Esther M. Bay 20a. Method of Disposition 1 Burial 2 Cremative 4 Donation 5 Othe	on 3 □ F	Removal from	State		8726 ace of Dispo metery, cre e of	osition (Na matory or	me of other plac	e)		ntgo: /200	20		- City or	MD 20886 Town, State
Baltimore,	permit. P Departme Importan any injuri 2008.		21. Signature of Funeral Serv				ouc	2:	2. Name a	nd Addre	ss of Facilit	y Hin	es R	inal	di Fu	nera	Home, Inc.
The state of	Pnysician /Medical Examiner	ıer	23a. Part. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ist only o	a. Sep Due to	each line. S is (or as a c	conseque	ence of):	07.7	de of dyin	g, such as	cardiac	or respirat	ory arres	t,		Approximate Interval Between Onset and Death 24 Hours
68760,	ficete be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	J		stric (or as a c		Diffi ence of):	cile	Coli	tis						24 Hours
.O. Box	The law requires that the death certifice ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			birth 2 i	Fetal	death 3	⊒Ectopic p ∃ Other (s					_		Date of de Month	livery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant con-			leath but i	not result	ting in the u	inderlying	cause giv	en in Part I						o the cause of death?
I Reco		Completed				·						—		Was an autopsy performe	ed?	prior to death?	utopsy findings available completion of cause of 2 XNo
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to med examiner?	-	Hospital:					1 0#			Check				
Division of Vital Records,	ding Phys n. After this of tuneral direction	ation: To	1 ☐ Yes 2 🗶 No 27. Manner of Death 1 凝Natural 5 ☐ Pe 2 ☐ Accident inv		28a. Date	Inpatient of Injury oth, Day Y	2	R/Outpatie 28b. Time o Injury		28c. Injur Wor					ce 6 C		ocify)
Divis	in the	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide del	uld not be ermined	28e. Place build	e of Injury ling, etc.	r - At hon (Specify)	ne, farm, st	reet, facto	ry, office			28f. Locat City o	ion (Stre or Town,	et and Nur State)	nber or R	ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifier (Check only 2 Medi	fying Phy cal Exam	rsician: To th iner: On the t and mar	e best of e pasis of e	xamınatio	vledge, deal on and/or in	th occurred evestigation	d at the tir n, in my o	ne, date an pinion, dea	nd place, ith occurr	and due to ed at the	the cau	ise(s) and i e and place	manner as e, and due	s stated. e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of cer	tifier	101	111			29	c. Licens	e number			290	d. Date sign	ned (Mont	ih, Day, Year)
	12		- Cluta	W.	()	Xla	h	M	9	D39	177			A	pril	24, 2	2006
			30. Name an address of per Curtis W. Ol					23a) (Type, Princ		lip.	Drive	, 01	ney,	Mar	y l and	208	332
報教室	Sta Registi		31. Date filed (Month, Day, Y. APR	2 8 2	.006	gistrar's	s Signati	K A	parti	,							

			1 - For State Registrar	State of Ma			artmer	nt of H			ental Hy	Reg. No.	20	06	15	148
J.	Physici		1. Decedent's Name (First, Middle, Last, MIRZ A	BAIG							2. Date of De Month	Day 2 (Year		3 o A M
	/Medic		4a. Facility Name (If not institution, give	street and number)					Location o		,		County	of Death	,	
	· **	19 ·	Lorien Nursir	1		and the land to the		1 Year	mbio If Under		O Date of Bi		ł	Juwa		to au Faurina
*	Funeral Director		5. Social Security Number 6. Security Number 223-60-0459 Usuat Residence of Decedent		68	ast birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 6/23		7	9. Birthpi Count Ind	ace (Sia try) lia	te or Foreign
	yland		10a. State 10b. County		-	, Town or Lo								10		e City Limits
	Ba-f si	ector	Md. Howard		COI	.umbia										Yes 2 X No
	h with th	al Dire	10e. Street and Number 5632 Thunder E	Iill Rd.				0 4 5					zen of v	Vhat Coun	tr y ?	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28a-f show other traumatic event, If a Medical Evaruitational bancillised at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 1 N If Yes, Give Year or Dates:		1	Was Dece f Yes, spe 1 ☐ Yes	cify Cuba	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto i	cify Yes or No Rican, etc.)		Blac	e - America ck, White, e Asi	etc.	1,
Maryland 21215-0036	I within 72 ho liene. r than "natur I've Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+>	16a. Deced (Give life. L Engi	kind of wi DO NOT i	ork done d ise retired	ation Juring mos)	t of worki	ng	En		onme onme		1
yland ?	ould be filed Mental Hyg wrked other	To Be C	17. Father's Name (First, Middle, Last) Mirza Bai	ig					Im	tia		Ba	ig			
Mar	alth and 2.5 is in 2.7 is in		19a. Informant's Name/Relationship (T) Imran Baig/ s								Rd., Co					1045
Baltimore,	Pages 1 and the int. If Item		20a. Method of Disposition 1		Ce	ace of Dispo metery, crem rge W	natory or	other plac			5/06			City or To		a
Balti	permit. Pages to Depertment of Himportant: if Ite any inlury or ot ance.		21. Signature of Funeral Service Mens	198	064	1			s of Facilit	O1	nivers				_	C20011
3 2	Physician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused ne cause on each lin Cerub	16.	. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory a				Approxi Interval	
	/Medical Examiner		resulting in death)	Due to (or as:	a consequ	ience of):	ial	fu	brelle	atro	due					
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience of):										
,092	icate be executed physician and s the burial-transit	Cal	resulting in death) Last	Due to (or as a	a consequ	ience of):										
P.O. Box 68	death certif e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[]Ectopic p] Other (s	regnancy pecify)					23d. Dat	te of delive	ry Day	Year
	w requires that the been signed by th should be detache	P	Part II. Other significant conditions co	ntributing to death bi	ut not resu	ulting in the u	nderlying	cause give	en in Part I	•		tobacco u Yes 2		nbute to th		of death?
il Records,	The lar	Completed									24a. Was auto perf 1 Yes		F	Were autoportion to condeath?	notetion	ngs available of cause of
Vital	Physician: T this certificet ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:				Oth			Check only	_				
ō	ng Phys fter this ineral di	tlon: To	27. Manner of Death 1. Natural 5 Pending	1 ☐ Inpatie 28a. Date of Injud (Month, Day	ry	ER/Outpatier 28b. Time of Injury		28c. Injun Work	/ at		me 5 ☐ Res 28d. Describe				′)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At ho c. (Specify	me, farm, str	reet, facto	ry, office			28f. Location City or To	(Street an wn, State		er or Aura	I Route /	Vumber,
	a Hospital 24 hours a Funeral C etely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner sta	examinat	wledge, deati	h occurre vestigatio	d at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s) date and	and ma	anner as st and due to	ated. the cau	se(s)
	To the within . To the	Med	29b. Signature and title of certifier				29	c. Licens	e number			29d. Dat	e signe	d (Month, i	Day, Yea	ar)
	10		1 Kain	WD				D	0 6 5 3	370	9		41	261	ن (
	ı		30 Name and address of person who c	1430	(7	allan	r F	Z X	lane	<u>.</u> S	TE #	210	E	3 a w i	e	MD
(e)	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 8 2	32. Fegistra	ar's Signat	B. A	carle	,							20	715

		•	1 - For State Registrar	State of Ma	aryland		artment of F		and Me		iene	006	15149
			Decedent's Name (First, Middle, Las	t)					2	2. Date of Deat	h		3. Time of Death
	Physicia		Hamida			Begu	m			April	30,	2006	9:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		Dogo.	4b. City, Town, o	r Location o	f Death		4c. C	ounty of Death	
			10900 Top Fli	te Court	;		Hage:	rstow	√n		V	Vashin	gton
	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs. las		If Under 1 Year Months Days		24 Hrs. 8	B. Date of Birth	Year)_	9. Birthr	place (State or Foreign
ш	Director		300-00-3100	JM 2LAF	82	Yrs.				JUI y 3	, 192	23 P	akistan
	pu 🔹		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	eation						10d. Inside City Limits
	sho	ō	Maryland Washin	aton			rstown						1 ☐ Yes 2 X No
	28a-	ect	10e. Street and Number	9 0011		nage	10f. Zip Code	-		1	0a. Citize	n of What Cou	ntrv?
	with Sa or	Ω	10900 Top Fli	te Court			217	42			-	kista	•
	within 72 hours after death with the Maryland ane. than "neturel", or Items 23a or 28a-f ehow the Modical Expenier must be notilied at	Completed by Funeral Director	11. Marital Status	12. Was Decedent I		. 13.	Was Decedent of H		gin? (Spec	ify Yes or No-		Race - Amen	can Indian,
က	or Iten	Ē	1 Never Married 2 Married	Armed Forces?	No				i, Puerto H	ican, etc.)		Black, White,	etc.
21215-0036	reli, o	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐XNo	Specify:			S	pecify:	White
2-0	72 honetur	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	dent's Usual Occup	during most	t of working	,	16b. Kind	of Business/In	dustry
21	nthin han	шþ	Efementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retired				0		
2	led w tygien her tl		17. Father's Name (First, Middle, Last)		and special section is a section of the section of	Н	omemake:		r's Namo /	First, Middle, I		vn Hom	e
ä	ntal H	Be			D						naiuon S		
Ž	d Me d Me mark matic	٦	Amir 19a. Informant's Name/Relationship (7)	vne Print)	Din	19h Mailir	ng Address (Street		eerar		City or 1		egum Code)
Maryland	d 2 s th an 27 is trau		Zubair Faridi	Son									and 21742
ē,	Hea Hea Hea Hea Other		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of matory or other place	1	Da			tion - City or To	
ě	Page: ent o nt: If ry or		1				emetery		04-30	0-06	Fred	erick,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if Item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Expening must be notified at any injury or other traumatic event, the Medical Expening must be notified at any injury.		21. Signature of Funeral Service Licen	See /	1	A 22	Name and Addre	ss of Facility	y Fur	neral H	ome	Tnc	
m	Depared Important Importan		R. hoely	Beady		40	<u> </u>	tietam	<u> Stre</u>	eet, Ha	gers	town, M	d. 21740
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	I the death. ne.	Do not ent	er the mode of dyin	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Cardia									Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
L	LAGITIMICI	_	Sequentially list conditions,	b. Diabet			tus						
	be:	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	xecul and	xan	that initiated events resulting in death) Last	c. Hypert Due to (or as									
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9	ificate g phy as the												
Вох	death certific e attending pl d for use as t	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23	d. Date of deliv	•
	the atte	icia	in the past 12 months? 1 🗆 Yes 2 🗷 No	4☐Pregnant at			Other (specify)	, 				Month	Day Year
P.0	ac ac	Physician/Med	9 🗆 Unknown										
	res tha igned (be det	by	Part II. Other significant conditions of	ontributing to death b	ut not result	ting in the u	nderlying cause giv	ren in Part 1.			oacco use os 2 🕱		he cause of death?
Records,	law requires as been sign 2 should be	Completed											
ec	elaw hasb e2sl	npie								24a. Was a autops perforr	У	24b. Were auto prior to co death?	opsy findings available empletion of cause of
al F	Th ate pag									1 Yes			2□ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth			(Check only on			
o	Phys r this ral di	1: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 2	R/Outpatier 28b. Time o	IL 3 L DOA	4 🗀 14u		e 5 🔀 Reside 3d. Describe ho		Other (Special	(y)
on	Attending r death. ector: After by the funer	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	fn j ury		rk? ∣Yes 2.⊟I	No				
Division	r Attending F er death. rector: After by the funera	ertification;	3 Suicide 6 Could not be determined	286. Place of in			reet, factory, office		28	If. Location (SI City or Town		Number or Run	al Route Number,
Ö	s afte	Cert	4 [Tiomode	building, et	с. (эрвспу)					Oily or Your	i, Siale)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical		ysician: To the best niner: On the basis of and manner sta	f examination								
	To th within To th compl	Me	29b. Signature and title of certifier	-			29c. Licens			2		signed (Month,	
				140-1			D 4	2145	7		5 -	2 - 20	vG
	4		30. Name and address of person who		leath (Item 2	23а) (Туре,	Print)						
	0		Abdul Waheed	MD			< Hill /	Avenu	е , Н	lagers	town	, Md.	21742
	Sta •Registi		31. Date filed (Month, Day, Year)	106 Jack	ar's Signatu	110	artical .						

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Cer	rtificate o	f Deat	h			Reg. No.	20	06 15	-
Physici Medical Exam			Danie		ker					2. Date of De Month April 28,	Day 2006	Year	3. Time of Death 2200 hrs	
		4a. Facility Name (if not in Rt. 40 West of A		reet and number)				Town, or L Spring	ocation of De	ath		County of Deat /ashington	1	
Funeral Director		5 Social Security Number 220 – 23 – 23	1M	le 7. Age 1		ast birthday) Yrs	Month	er 1 Year IS Days	If Under 24 Hours	Min. 8. Date of B		Forei	rthplace (State or gn gn buntryMD	Ī
Maryland 28a-f show any sd at once.	Director		ashing	ton		Town or Locat	ring 10f. Zip	Code		1		en of What Cou	10d Inside City Limits 1 X Yes 2 No	
with the M as 23n or 2 be notified		12340 Nac		P1KE 2. Was Decedent E	ver in U.	S. 13. Wa		21722 ent of Hispa		Specify Yes or No		U,S.A.	ican Indian, Black,	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiens 27 is marked other than "natural", or items 23a or 28a-f 5the minatic event, the Medical Examiner must be notified at once	by Funeral	1 X Never Married 2 3 Widowed 4 15. Decedent's Education	Divorced If N	es, Give Year	X No	1 []	es, specif	iy Cuban, I	Mexican, Pue specify	rto Rican, etc.)		White, etc. Wh : Specify:	ite	
0036 within 72 hou iene er than "nati Medical Exa	Completed	Elementary/Secondary 10th grad	le (0-12)	College (1-4 or 5+			ost of work	king life D	O NOT use	retired)	pι	ablic s	•	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be	17. Father's Name (First, William	Leon B					18 I	Mother's Na Laura	me (First, Middle, L. Man	Maiden S Zana	ares		
두 명부 등 등	To	19a Informant's Name/Re Laura L.	Parks	mother		1254	40 N	atio	onal I	or Rural Route Nur Pike Cl	ear	Spring	7, MD 21722	7
Baltimore, I permit Pages I and Department of Healt Important: If item injury or other tra.		20a. Method of Disposition 1 X Burial 2 Cru 4 Denation 5 0 21. natur of Funeral 5	emation 3 ther Specify:	Removal from State	RO RO	Place of Disposi rematory or oth SE Hi	er place)	emet	ery 2	1ay 4, 2006	Cle		ing,MD	
		Cint	Ch			P.	onal Onal	Address of d Ed OX 3	[Facility [W] n [O C]	hompson ear Sp	n Fu	neral	Home, Inc	
Physician /Medical Examiner		23a. Part I. Ente v e dise failure. List only one Immediate Cause (Final o	isease a. Mu	tions that caused th ine. Itiple Injuries	e death.	Do not enter th	e mode o	f dying, su	ich as cardiai	or respiratory arr	est, shoc	k, or heart	Approximate Interval Between Onset and Death	П
		or condition resulting in d Sequentially list condition		to (or as a consequ	uence of):								
	Examiner	if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)	te Due Cause iated C	to (or as a consequent to (or as a consequent										
executed an and al - transit	edical E	UNPENDED	d	MENDED										4
8760, tificate be executed ng physician and as the burial - trans	∑I	IF FEMALE: 23b. Was decedent pregna		3c. If yes, outcome	of pregn				1			Date of delivery		\dashv
Box 687 he death certifing the attending hed for use as t	Physicia	past 12 months?	Linknown 4		ne of dea	ath	al death er (S <i>peci</i>		Ectopic preg	nancy	N	Month D	ay Year	
P.O. es that the igned by the detacl	ğ	Part II. Other significant	conditions cor	ntributing to death b	ut not re	sulting in the ur	nderlying	cause give	en in Part I.				he cause of death? ably 4 Unknown	
Division of Vital Records, at or Attending Physician: The law requires after cleath all Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed									24a. Was a autop perfor	sy med?		opsy findings available ompletion of cause of	1
fital Fisician: sician: s certifi irector,	a	25. Was case referred to rexaminer?	Hosp	ital:	• • • • • • • • • • • • • • • • • • •	EB10 4		04	Death (Chec	k only one)				1
ing Physianeral d	ñ: ٦	1 Yes 2 N	lo I	1 Inpatient 28a. Date of Injury (Month, Day, Year		ER/Outpatient 28b. Time of In		Bc. Injury a		28d. Describe h	now injury		Scene	+
ision Attend er death rector:	Certification:	Natural 5 2 Accident	Pending Investigation	Apr 28, 2006 28e. Place of Injury		2109 hrs	factory		2 No	Driver auto a	_		al Route Number, City	
Divisior ospital or Attend hours after death meral Director:		3 Suicide 6 4 Homicide 29a. Certifier 1 Certifier	Could not be determined	(Specify) Highw	way					RT. 40 , Cle	_{tate)} ar Spri	ng, MD		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical	one) 2 Medic	al Examiner:On and	To the best of my ke the basis of examin I manner stated	nowledge nation and	e, death occurre d/or investigatio	ed at the ton, in my o	time, date opinion, de	and place, areath occurred	nd due to the cause at the time, date a	e(s) and i	manner as starte e, and due to the	ed. cause(s)	
M	Σ	29b Signature and title of	-	-Ra	·L		- 1	License ni O.C.M.I				ite signed (Moni 29, 2006	h, Day,Year)	
6	1	30. Name and address of Patricia Aronica-I		oleted cause of deal Assistant Med		,	111 Po	nn Strac	at Rollins	ore, MD 21201				1
	ate	31. Date filed (Month, Day	and the same of th	32. Registrar's	Signature	9.			or, Daillill	, WID 21201				-
Regist	TEN.	11711	A MA WAR	NOTE STATE	200	1-1								1

			1 _ For	State of Ma	-	•	Health and	Mental Hyg	giene	0.0	f has a hom a
			Registrar			Certificate o	of Death		leg. No. 🚄 🔱	Ub_	15 5
- 18 A	Physici	an	Decedent's Name (First, Middle, La		72 =			2. Date of Dea	Pay .	Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, gi	sennett	Dot	Man	n, or Location of Deat	Hpr	4c. County	2006	3:53₽
	Examir	ıer			edical Con	22.1	12	ın	. 4	i a	
	Funeral	-			clical Cen	day) If Under 1 Ye			N	9. Birthplac	ce (State or Foreign
	Director		220-32-2154	181M 2□F 6	9 Y	rs. Months Day	ys Hours Min.	May 8,	1936	Country VA)
	p ,		Usual Residence of Decedent		10.00						
	anyla shov	7	10a. State 10b. County		10c. City, Town					10d	I. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-f	ect	MD Worceste	er	Ber				10- Oilif 14		
	with the or	Funeral Director	11744 Gum Poin	t Da		10f. Zip Code	21811		10g. Citizen of W	vnat Country	/ (
	death ms 20	era	11. Marital Status	12. Was Decedent B	ever in U.S.	13. Was Decedent of		Specify Yes or No-	USA 14. Race	- American	Indian.
9	or Iter		1 ☐ Never Married 2X Married	Armed Forces? 1 X Yes 2 □ N	o		of Hispanic Origin? (Suban, Mexican, Puer	to Rican, etc.)	1	k, White, etc	
8	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a profiled at event, the Madical Examinar must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Year or Dates:	961-69	1 □ Yes 2 🔼 N	No Specify:		Specify	White	
5	72 h	etec	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. [Decedent's Usual Oct Give kind of work do	cupation ne during most of wo ired)	rking	16b. Kind of Bu	siness/Indus	stry
121	within lene. then	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)	ife. DO NOT use ret Pharmacis			Dham	aceut	iosl
2	filed Hygie ther	e Co	17. Father's Name (First, Middle, Las	5±		Tharmacis		me (First, Middle,			ICal
an	ould be Mental arked o	To Be	S. Russell Bo	-				Bennett	maidon daman	-,	
Maryland 21215-0036	₹ B E E	F	19a. Informant's Name/Relationship		19b.	Mailing Address (Stre	et and Number or R		r, City or Town,	State, Zip Co	ode)
	d d d d d d d d d d d d d d d d d d d		Elizabeth S. Boz	zman			oint Rd.,				
Jre,	es 1 an of Heel of Heel r other	1.8	20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other p			20c. Location -		n, State
Ē	Pagent ont: I	1	1 □XBurial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci		1	, ,	Park 5-2	2-2006	Berlin,	Mary	land
Baltimore,	permit. Pag Departmen Importent: any injury once.		21. Signature of Funeral Service Lice	nsee		22. Name and Add	dress of Facility T	he Burbag	e Funer	al Hor	ne
_	207299		March	ulale			illiam St			1811	
**************************************			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do no	t enter the mode of o	tying, such as cardia	c or respiratory arr	est,	ln ln	pproximate iterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a INte	ction	- Dres	umed s	repsis			nset and Death
	/Medical Examiner		Tosulaing in doutin)	Due to (or as a	consequence of):		•			0 1.
**		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of	ous pr	ricess of	uning	enolog	Y	Z CLAYS
	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,.				27/2	
Ć.	exection and its its	Еха	resulting in death) Last	c. Due to (or as a	consequence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	cai		_ d.							
9	h certifica ending ph use as th	P	IF FEMALE:								
Вох	eath ce attendi for use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	of pregnancy 2 Fetal death	3 □Ectopic pregnar	псу			of delivery	
_	it the dea by the at tached fo	Physician/M	1 Ves 2 No	4☐Pregnant at t		5 ☐ Other (specify)			Mon	ith Da	ay Year
P.0	that the		Part II. Other significant conditions	contributing to death bu	t not resulting in	he underlying cause	annon in Part I	23a Did tol	pacco use contri	buta to the	rougo of death?
Records,	signe d be	d by	Congestive	hoart	Pailu	V0	given in raiti.			3 Probabl	N/
Ö	w requir been s should	Completed	Diagolas	1.004.1	100,00		-				
Re	The lay	E P	Diabetes	00				24a. Was a autops perform	y p		findings avaitable letion of cause of
Vital	ician: T certificat rector, pa	C	25. Was case referred to medical	ufficient	CY		ac Disease A Day	1 ☐ Yes 2	No 1	Yes 2	□ No
>	Physician: r this certific ral director,	0 B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatier	nt WEW utp	atient 3 DOA	Other	ath Check only on Home 5 ☐ Reside	*	r (Spacific)	
1 of	iding Physician: th. After this certifical funeral director,	n: T	27. Manner of eath	28a. Date of Injury (Month, Day	/28b. Tir	ne of 28c. In		28d. Describe ho			
io	Attending r death. ector: After by the fune	atlo	1 Natural 5 Pending investigation	n	Yθar) Inj		Yes 2 No				
Division	or Attendate death after death Director:	Certification	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farn (Specify)	n, street, factory, office	ce control	28f. Location (St City or Town	reet and Numbers, State)	or Aural R	oute Number,
	pital c		200 Continu								
	To the Hospital or Attentwithin 24 hours after deation to the Funeral Director: completely filled in by the	edical	29a. Certifying Pl (Check only one)	hysician: To the best of miner: On the basis of and manner stat	examination and/	death occurred at the or investigation, in my	time, date and place y opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and mar ate and place, a	ner as state nd due to th	ed. e cause(s)
	within 2 To the	Med	29b. Signature and title of certifier	and manner stat	ou.		ense number		9d. Date signed		
	⊢ s ⊢ ŏ		000000	Con	LIT	0	191810		n = -	\sim	000/-
			30. Name and address of person who	completed cause of de	ath (Item 23a) (T	ype, Print)	11404		P	J 1	SOUV
8	T 104		Cristalle A	Istrid (cx 2	2. South	Greene	St. Bo	utimore	MD.	21201
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Registra	r's Signature	had.				A CARGO	

			State of Maryla 1 - State Registrar	•	artment of rtificate of			giene 2006	5 15152
	Physicia		1. Decedent's Name (First, Middle, Last) Saturnino Contreras				2. Date of De Month April	29, 2006	3. Time of Death 1:45 p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of		4c. County of Dea	
	Examili	e.	8218 18th Avenue		Ну	attsvi	11e	Prince G	eorge's
	Funeral Director		4 X 14 0 7 5	rs. last birthday)	If Under 1 Yea Months Day		Min. 8. Date of Bir (Month, Da May 3,	9. Bir 1947 E1	thplace (State or Foreign ountry) Salvador
			Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary med sho	tor	Maryland Prince George's	Нуа	attsvill	e			1 X Yes 2 □ No
	or 284	Direc	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	
	s 23a	erai	8218 18th Avenue 11 Marital Status 12. Was Decedent Ever in	110 12		783	nin? (Specify Voc or No	El Salv	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any figury or other traumatic event, it is Maryland Exa. intert. intert. in the modified at ODGe.	Completed by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever if Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu 1X Yes 2□ N		gin? (Specify Yes or No i, Puerto Rican, etc.) Salvadoran	Black, Whi	te, etc.
215-0	hin 72 ho e. an "netur Madical	pieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during most red)	t of working	16b. Kind of Business	
2	led will lygien her tha	Con	5th	Floo	or Clean		r's Name (First, Middle,	Cleaning	Company
/land	uld be fii Mental H irked otl itic ever	To Be	17. Father's Name (First, Middle, Last) Concepcion Contreras			Mag	dalena Rios		
Mary	nd 2 sho lith and I 27 is me r traums		19a. Informant's Name/Relationship (Type, Print) Vilma Sarmiento/ daughter	8218	18th Av	enue	and 20783	er, City or Town, State,	Zip Code)
Baltimore, Maryland 21215-0036	Pages 1 ar ent of Hea nt: If item ry or othe		1 ABurial 2 Cremation 3 Bemoval from State	b. Place of Dispo	osition (Name of matory or other p	lace)	Date May 5, 2006	20c. Location - City of La Union El Salv	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee Wanda C. Racow. CC =	- /			yW.H. Bacon t, N.W. Was	Funeral H	ome, Inc.
ì			23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.			-		rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a Due to (or as a condition)	sequence of):	met	astas			
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	sequence of):	Cance	^			
8760,	cate be executed obly sician and the burial-transit	ıi Examiner	Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a con	sequence of):					
687	icate t physic	adica	d						
.O. Box (Ihat the death certificated by the attending placed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of de Month	olivery Day Year
Ω.	96	by	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause	given in Part I.		obacco use contribute t Yes 2□No 3□P	o the cause of death?
Vital Records,	The law ate has b page 2 si	Completed					24a. Was autor perfo	osv prior to	utopsy findings available completion of cause of
/ita	vysicien: Th nis certificate director, pag	Be (25. Was case referred to medical examiner?				of Death (Check only o		
of	dis di	. To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient : 27. Manner of Death 28a. Date of Injury	2 ER/Outpatie			rsing Home 5 X Resi	dence 6 Other (Spe	ecify)
	ding n. After fune	tlon	1 Matural 5 Pending (Month, Day Yea 2 Accident investigation	r) Injury	W	/ork? ☐Yes 2 ☐ I		now injury occurred	
Division	or Attending after death. Director: Aftel in by the fune	Certification;	3 ☐ Suicide 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, offic	ee e	28f. Location (. City or To	Street and Number or R wn, State)	ural Route Number,
_	Hospitel	edicai Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the evestigation, in my	time, date an y opinion, dea	d place, and due to the the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the Complex	Me	29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signed (Mon	th, Day, Year)
}	(1)		I manon O. Ullet	zu.	D237	43		May 2, 20	06
2	4		30. Name and address of person who completed cause of death (Martin Weltz, M.D.	Item 23a) (Type,			nway Court , Maryland,		
ľ	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2006	gnature	W				

•	(3	200	1964	
State of Maryland / Department of Health and Mental	HygieneZ	U	U	-

			1 - For State Registrar	State of I	Maryland / Depa <i>Ce</i>	artment of F <i>rtificate of</i> :			giene∠ U U b Reg. No.	15153				
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath Day Year	3. Time of Death				
н	Physici /Medi		Veasey B.	Cullen				April	26, 2006	4:05 р м				
	Examir		4a. Facility Name (If not institution, g		<i>'</i>	_	r Location of Death	1	4c. County of Deat					
			26348 Arcadia S			Eas		.,	Talbot					
ı	Funeral Director		221-03-9439	Sex 1	Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Dec. 18	9. Birth 8, 1909 Mar	nplace (State or Foreign untry) y Land				
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits				
Q	Maryti -f sho	tor	Maryland Talbo	t		East	on			1 ☐ Yes 2 ☑ No				
B	th the	Olrec	10e. Street and Number		_	10f. Zip Code	24604		10g. Citizen of What Co	untry?				
5	ath w	ral	26348 Arcadia Sl				21601		USA					
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "netural", or Items 23a or 28a-f show or other traumetic event, Ita Medical Exam	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	₽ No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.				
5-0	72 ho	eted	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of Business/					
121	within iene. than	dm	Elementary/Secondary (0-12)	College (1-4	or 5+)	no not use retired employed 1	-		Industrial	sumplies				
	filled Hygie sther	င်	17. Father's Name (First, Middle, Las	st)	5322	projec			Maiden Sumame)	варриись				
an	ould be Mental arked o	To B	Winter Calvert	easey										
Maryland	2 should and Men is marke aumetic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip											
	and 2 salth a n 27 is		Jane Veasey Cull	en/Daught		Weathers								
Baltimore,	of He If iten		20a. Method of Disposition 1 Surial 2 Peremation 3	☐Removal from Sta	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	ce)	Date	20c. Location - City or	Town, State				
Ë	. Pages tment of tant: If it		*4 □Donation 5 □ Other (Spec	city)	Woodlawn				Easton, Ma	ryland				
Bai	permit. Pages 1 and Department of Healti Important: If item 2? eny injury or other i <u>once.</u>		21 Ignature of Fun ray Service Lice	ensee	(1,1,0,0)		Shwell Fu	meral Ho	ome, P.A.					
			23a. Part 1. Enter the disease, or co	mplications that cau	sed the death. Do not en	808 High Ster the mode of dyin				Approximate				
	Physician		shock, or heart failure. List on Immediate Cause (Final	y one cause on eac	ARDIAC	CALL	06			Interval Between Onset and Death				
	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequence of):					60 min				
	Examiner	L.	Sequentially list conditions,	bK		RY FA	ILURU			60 min				
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):	TACT	INFEC	Tival		3 Weeks				
	ficate be executed physician and s the burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):	ITCL	1101 60	110,0		O WEEKS				
68760,	sicial sicial e buri	edicai I		d										
	rtifical ng phy as th		IF FEMALE:											
P.O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal death 3 [it at time of death 5 [Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year				
of Vital Records, P	uires that n signed b Id be deta		Part II. Other significant conditions PROSTAT		th but not resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	2				
Ö	aw requir s been si 2 should	Completed	Recurren	+ wind	ing tract	infect	7000	24a. Was a		topsy findings available				
B.	The la ate ha	mo			J	1		autop perfor 1 Tyes		ompletion of cause of 2 2				
/ita	cien: ertifica ector,	Be	25. Was case referred to medical examiner?			l du		th (Check only or	ne)					
of)	Physi this o	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inp			4 Nursing H		ence 6 Other (Spec	ify)				
ion	Attending Physicien: If death, ector: After this certification, by the funeral director, it	ation	1 Natural 5 Pending 2 Accident investigati	1	Day Year) Injury	Wor	yat k? Yes 2 □No	28d. Describe ii	ow injury occurred					
Division	tal or Atters a ster de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 289. Place of	lnjury - At home, farm, st , etc. (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,				
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basi and manne	est of my knowledge, deat is of examination and/or in r stated.	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the d rred at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)				
)	To the within To the comp	Ň	29b. Signature and title of certifier	(Sesso)	mo Phys	uan D60			April 27					
			30. Name and address of person who	o completed cause		Deine								
_			JUJETH M. 1369	>= 11-14	- 10.0.	111017	JI Juck	- 5 - 7 - 1	- waters / 12					

DHMH 17 Rev 1/2001

Registrar

		•	For Stata Ragistrar	State of M	•	epartment of I			giene 006	15154
			1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month	th Day Yea	3. Time of Death
	Physici /Medio Examin	al	Laurena Creightor 4a. Facility Name (If not institution, gi		·)	4b. City, Town, o	or Location of Dea	April 3	0, 2006 4c. County of De	2:15 A ^M
1	X		Talbot Hospice H	louse		Easto			Talbot	
	Funeral Director				ge (In yrs. last birth	Months Days	If Under 24 Hr Hours Mir		Year) 9. E	irthplace (State or Foreign Country) Maryland
	pu		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
5	a-f shor	ctor	MD Talbot	-			Michaels			1 ☐ Yes 2 🗹 No
)	ith the	Dire	10e. Street and Number	_		10f. Zip Code	24.442	1	log. Citizen of What	Country?
)	s 23e	rai	1019 Riverview	12. Was Deceden	t Everia II S	13 Was Daggdoot of I	21663	Specify Ves or No-	USA	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show important; or Items 27a or 28a-f show any injury or other traumatic event, the Madical Exercificat: and be notified at 2008.	by Funeral Director	Marital Status Never Married 2 Married Married 4 □ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No.	 Was Decedent of I If Yes, specify Cub Yes 2 No 	an, Mexican, Pue	orto Rican, etc.)	Black, Wi	
21215-0036	72 hou neture	Completed	15. Decedent's l	Education rade completed)		Decedent's Usual Occup Give kind of work done	during most of w	orking	16b. Kind of Busines	ss/Industry
121	vithin ne. han "	mpi	Elementary/Secondary (0-12)	College (1-4or	r 5+)	owner/ope	•		furniture	a store
2	filed withi Hygiene. other than ent, tre M		17. Father's Name (First, Middle, Las	it)		Owner/ope		ame (First, Middle,		e store
an	Mental Merked o	To Be	Arthur Creight					Creighton		
Maryland	2 should and Men is marke aumatic	F	19a. Informant's Name/Relationship		19b. l	Mailing Address (Street				, Zip Code)
	1 and 2 Health a tem 27 is		Linda Parks	daughte:		19 Rivervi	ew Terra			
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	nomatan:	Disposition (Name of crematory or other pla	сө)		20c. Location - City	or Town, State
tim	permit. Pag Department Important: I any injury o		'4 □Donation 5 □ Other (Spec	ify)		ter Memoria		5/2/06	Cambrid	
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Lice But 16. But	ensee		22. Name and Addre			neral Home MD 21613	
			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that cause y one cause on each	ed the death. Do no line.	t enter the mode of dyi	ng, such as cardi	ac or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a	stroke					10 0445
1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):				, _
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Colorado or injury	b. Due to (or a	s a consequence of):				
o,	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):				
8760,	ate be hysici the bu	licai		d						
.O. Box 68	that the death certificate be executed od by the attending physician and detached for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown		2 ☐ Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у	-	23d. Date of o	delivery Day Year
Δ.	es De de	d by Ph	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying cause gr	ven in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
Records,	ne law requir has been si ge 2 should	Completed						24a. Was a autops perfor	sy prior t med? death	
Vital		e Co	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only or	2 No 1 Y	es 2 de No
of	ding Physician: The lav h. After this certificate has funeral director, page 2	To B	examiner? 1 Yes 2 Ho 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpa 28a. Date of In (Month, C		ne of 28c. Inju	her: 4 Nursing ry at rk?	Home 5 Reside		DECITY) HOSPICE
Division	or Attendated death	Certification:	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of I	njury - At home, farr etc. <i>(Specify)</i>	M 1]Yes 2□No	28f. Location (S City or Town		Rural Route Number,
	Hospital 24 hours a Funeral stely filled	edicai C	(Check only 2 Medical Ex	aminar: On the basis	of examination and	death occurred at the to				
	thin 2 the I the I	Med	one) 29b. Signature and title of certifier	and manner	stated.	29c. Licen	se number	2	29d. Date signed /Mo	nth, Day, Year)
	To To		1 Gran A	1/2/15		H51	792		5/1/06	2
			30. Name and address of person wh	o completed cause of	death (Item 23a) (T	(ype, Print)	C	band.	UP DIE	12
	* 0.	ate	31. Date filed (Month, Day, Year)	32. Regis	tygr's Signature	174n 11	Cam	rir (cise	IN ONE	
	Regist		MAY 0	2 2006	Marine de	& Speck	1			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State Registrar Amended items 23a. PartI. & 2 Pertificate of Death wichd/05/09/2006/d1s 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 0148 Charles Edward Coles 2006 April 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Director 230-64-3396 57 Nov 4, 1948 VA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. fnside City Limits 28a-f shov the Mudical Exactines must be notified at MD 1 XYes 2 No Worcester Director Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 9826 Hotel Road 21813 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or stems 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Bfack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Restaurant Equipment other than Elementary/Secondary (0-12) College (1-4or 5+) Rental Laborer unknown injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othing any injury or other traumatic event RRE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 unknown Carrie Coles ーント 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Massey/friend 9826 Hotel Rd., Bishopville, MD 21813 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery 4/29/2006 Berlin, MD 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Partial Bowel Obstruction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiac Arrest Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 4-339(Records, P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CANCER 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 7 SEVELAC 1 ☐ Yes 1 ☐ Yes 2 No 2 No 230 - 60Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 💓 No Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA Director: After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident Could not be 3 🗌 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 29 Bruto SI SMITE 201 31. Date filed (Month, Day, Year) State 26 2006 Registrar

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	Funeral Director	C.Probe	170-10-6435	. Sex 1 ☐ M 2 💢 F	n yrs. last birthday) 81 Yrs.	If Unde Months	r 1 Year Days	If Under 24 H Hours M	Ain. (Mor	of Birth oth, Day, Yes 5,19	9. 8 24	lirthplace Country) PA	(State or Foreign
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	th wit	alD	14201 Lancaster	Lane			20715				USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health 27 is marked other than "natural", or Itame 23a or 28a-f ahow other traumatic event, In Macical Exactinational be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ XMarried 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes		spanic Origin? n, Mexican, Pi Specify:	? (Specify Yes uerto Rican, e	or No-	14. Race - An Black, Wi Specify:		
2-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usu	al Occupa	tion uring most of	workina	16b.	Kind of Busines	ss/Industry	
121	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT L	ise retired)	-		D	-4-47		
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Maryland	2 should be filed with and Mental Hygiene. Is marked other than aumatic event, It of	To Be	Antonio Rivello	*					la Vol		en Sumame)		
ary	shou and M amar umat	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Addres	s (Street a	nd Number or	Rural Route	Vumber, City	y or Town, State	, Zip Code	n)
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr 2052.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	20b. Place of Dispo cemetery, crei Ft. Linc	natory or o	other place	ery 4	Date /29/200		Location - City of entwood		tate
Balti	permit. Pages Department of Important: If II eny injury or o		21. Signature of Funeral Service Lie	ensag				s of Facility polis		E. Ev Bowie,	ans Fun	eral 715	Home
S. Oak			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the							1ID 20	Appl	oximate val Between
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Ser.	/Medical		resulting in death)	Due to (or as a c	onsequence of):		7,000	arec					
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of Vital Records, P	uires that the de signed by the a ld be detached t	ρ	Part II. Other significant condition:	contributing to death but n	ot resulting in the u	nderlying o	ause give	n in Part I.	23e.	Did tobacco	o use contribute 2 □ No 3 □ F	to the cau	se of death?
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Re	The la	E	0004	, 0					- _	autopsy performed?	prior to death?	completi	on of cause of
ita	ifcien: Th certificete rector, pag	0	25. Was case referred to medical					26. Place of D	1 □ 1 Death Check		NO TILI YE	s 2□N	10
<u>_</u>	hysicie nis cert i direct	To B	examiner? 1 ☐ Yes 2 € No	Hospital: 1 Inpatient	2 ER/Outpatier	t 3 🗆 D	Othou		- 43	20-10	6 ☐Other (Sp	ecify)	
	iding Ph th. : After th funeral		27. Manner of Death ↑ ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	2	28c. Injury Work	at ?	28d. Des	cribe how in	jury occurred		
sio	uttendi death. ctor: A y the fu	cati	2 Accident Investigat 3 Suicide 6 Could not	he		М		es 2 No					
Division	To the Hospitel or Attend within 24 hours after death To the Funerel Director: , completely filled in by the f	Certification:	4 Homicide determine	building, etc. (\$	Specify)				City	or Town, Sta			e Number,
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•			30, Name and address of person wh	o completed cause of death) (It -m 23a) /Tuno	Print)	رر	WHITE OF	YU)	$\perp C$	112	010	4
			600 Riche	dy Ave	Suite-	#2	311	Aditya		15.1	mo	NIG	01
	Sta Registr	2.0	31. Date filed (Month, Day, Year)	37 Registrar's	Signature	M)			1	1			

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Alan Carr 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Deatl Physician/ 0820 hrs April 26, 2006 **Medical Examiner** ALAN CARR c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard Glenelg 4203 Buckskin Lake Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign NEW YORK 5. Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 1 X M 2 Yrs 42 196 057-62-3192 JUNE Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County any 10c. City, Town or Location 1 Yes 2 No 28a-f show with the Maryland MD BALTIMORE Director 10f. Zip Code 10g Citizen of What Country 10e. Street and Number U.S.A. 21206 6008 NAHANT ROAD 23a Funeral 11 Marital Status Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Married hours after death Yes 9 BLACK Yes 2 X No specify. Specify Widowed 4 Divorced If Yes, Give Year the Medical Examiner "natural" ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hot
Department of Health and Mental Hygiene
Important: If Item 27 is marked other than "mat
injury or other traumatic event, the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) Complet 12th TRUCK DRIVER PRIVATE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) CHARLENE TUMLIN ALFRED CARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 HOWARD AVENUE BROOKLYN NEW YORK ALFRED CARR/FATHER 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 CYPRESS HILL CEMETERY 5/3/2006 BROOKLYN, NEW YORK Other Specify 4 Donation 5 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21: Signature of Fune 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I. Enter the disease, or complications th caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Retween Onset and Wedical Death a Asphyxia and multiple injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one 25. Was case referred to medica director Be examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Residence 6 🗸 Other: Scene this 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Apr 26, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Subject driver ejected from trashtruck 0813 hrs 1 Natural 1 ✓ Yes 2 No Pending 2 🗸 Accident Investigation þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town State determined (Specify) Local Street 4203 Buckskin Lake Drive, Glenelg, MD 24 hours a 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 27, 2006 O.C.M.E. edu 11 30. Name and address of person who complete see of death (Item 23a) Theodore King MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

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State

				For State Registrar	State of	Maryland / Dep Ce	partment of ertificate of			ene g. No 2 0 0 6	15158
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		Examin	er	4a. Facility Name (If not institution, given DOCTORS COMMUNITY				or Location of Death LANHAM		PRINCE	
		Funeral			Sex 7.	Age (In yrs. last birthda) If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
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Junning	5-0036	within 72 hours after death wi ene. then "natural", or items 23a he Medical Examinar must b		15. Decedent's E		16a. Dec	edent's Usual Occu	upation	10	6b. Kind of Busines	s/Industry
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1	ē,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 ls any injury or other trau		20a. Method of Disposition	<u> </u>		position (Name of rematory or other pl			Oc. Location - City o	
7	E C	Page: lent o nt: If iry or		XX Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		219		CEM. 05/	01/06	LAUREL, M	4D
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	ion	ath. pr: Aft	atio	1 ✓ Natural 5 ☐ Pending investigate	on	Day Year) Injury		☐ Yes 2 ☐ No			
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^	0	(2)		30. Name and address of person had	completed cause	of death (Item 23a) (TV)	erPrint)	AVa	Laure	PMA "	20707
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			MEMORIAL HOSPIT. 5. Social Security Number		e (In vrs. la		der 1 Year		4 Hrs. 8	I. Date of Birth		9. Birth	place (State	or Foreign
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	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	5. 13. Was D	ecedent of H	lispanic Origi	in? (Speci	fy Yes or No- can, etc.)		Race - Ameri Black, White		
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow ta Medical Examinar maat be inclified at	etec	15. Decedent' (Specify only highes			16a. Decedent's (Give kind o	work done	durina most (of working	,	16b. Kind of	Business/Ir	ndustry	
21	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or	5+)		T use retired							
2	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural, or Items 23s or 28s-1 show event, Ita Medical Examinar must be invitted at	Completed	11			Dies	el Mec		l- Nama /	Time & Adiabatic A		sporta	tion	
2	be fill htal H d ott	Be	17. Father's Name (First, Middle, L	_		0 11.		18. Mother		First, Middle, N	naiden Sun			
<u>ya</u>	2 should be filed within and Mental Hygisne. Is marked other than aumatic event, Ita M	၉	Chester	Roy		Collins			Lill			Gree		
Maryland	2 sh and le m		19a. Informant's Name/Relationsh			19b. Mailing Add								
	s 1 and 2 should of Health and Men Item 27 is marks other traumatic		Carol A. Collin	s / wife	Jack Bi	11818 A			ue, C	-		MD ZI on-CityorT	502	
Baltimore,	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 □Removal from State	1	ace of Disposition emetery, crematory		}						
Ë			4 □ Donation 5 □ Other (Sp		Mt.	Hermon						erland		
3a	Departr Departr Importe eny Inje		21. Signature of Funeral Service L	icensee	1					ıs Fami				P.A.
	<u>v</u> ∪ = • α		Kalut C	, Heling	11					Cumbe		, אוט	21502	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused by one cause on each	he.	Do not enter the	mode of dyir	ng, such as c	ardiac or	respiratory arre	est,		Approxima Interval Be Onset and	etween
1	/Medical		resulting in death)	Due to (or as	a consequ	ience of):		7010)
	Examiner		Sequentially list conditions,	b	neson menin									
	₽ ∺	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dug to for as	a consequ	iones of):								
	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	2.0000000	ionae ath						-		
760,	cian d		,,	Due to (or as	a consequ	ierioe orj.								
87	cate b	dicai		d										
x 68	entific ling p	Me.	IF FEMALE:	23a li van autanma	of progna	201								
Вох	ath c	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3 Ector	c pregnancy (specify)	1				Date of delive Month	Day	Year
-	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t time of de	aatin 5∐Othe	(specify)_							
P.O.	The law requires that the death certifica tie has been signed by the attending phoage 2 should be delached for use as it		Part II. Other significant condition	ns contributing to death b	ut not resu	ulting in the underly	ng cause giv	ren in Part I.		23e. Did tol	acco use c	ontribute to	the cause of	death?
ds,	8 6 g	d b	chanic	(202)	211	350				12XY	s 2 No	3 ☐ Pro	bably 4	Unknown
Records,	requ	Completed	Charic	hal- li	^ -	1	. ~	Cane	_	24a. Was a	0.4	lh Mara aut	anny findina	a avadabla
3eC	e law	Ig Ig	<u>Chronic c</u>	DETROCTIV	6 b	\$100000	y c	11200	26	autops perforr	y	b. Were aut prior to co death?	ompletion of	cause of
a	n: Th icate			100000000000000000000000000000000000000						1 ☐ Yes 2	NO DIAME	1 🗆 Yes	2 □ No	
Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	- 0		DOA Oth			Check only on		0.1. /0		
of	Phys this ral di	<u>1</u>	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatient 3[28b, Time of	JOON	4 1401		e 5 ☐ Reside			ify)	
U	ath. rr: After	lon	1 datural 5 ☐ Pendin	(Month, Da	y Year)	Injury	28c. Injur Wor	rk? Yes 2 □ N			,_,			
Division of	Attender deatlector:	Certification:	3 Suicide 6 Could r	ot be One Bleen of In	iurv - At ho	me, farm, street, fa				If Location (St	reet and Nu	ımbər or Rui	al Route Nu	m <i>ber</i> ,
ĕ	or A after Direction	ertil	4 Homicide determine	building, e	c. (Specify)	,,			City or Town	, State)			
	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	0	29a. Certifier Certifyin	g Physician: To the best	of my know	wledge, death occur	rred at the ti	me, date and	place, ar	nd due to the ca	ause(s) and	manner as	stated.	
	24 h Fur etely	Medical		Examiner: On the basis of and manney st	f examinat	tion and/or investig	ition, in my o	pinion, death	h occurred	d at the time, d	ate and place	ce, and due	to the cause	(s)
	To the within To the comple	₩ W	29b. Signature and title of certifier	2011			29c. Licens	se number		2	9d. Date sig	ned (Month	Day, Year)	
,	F ≤ F ō :		11.0	K/Stona				D1001	6		4/2	0/06		
2	/IVA		30. Name and address of person	who completed cause of	death (Item	23a) (Type Print)		D1821	0		-/-	-		
	nas			·	•	IORIAL AV	ENUE	CHMBET	RT.ANT), MD 2	1502			
	Sta	ate	SMITH, STEVEN 31. Date filed (Month, Day, Year)	37 Regist			و تلان الالت	COLIDE	WINT	2 LIL 6				
	Regist		APR 2 1 2	006	1	Concatt	,							

			For 1 State	State of Marylan		artmen rtificat			nd Me		4	200	C	15160
			Registrar		Cei	lilical	e or L	Jeani		2. Date of Dea	Reg. No.	4001	0	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)				1			Month	Day	Year	r	
,	/Medic		JOHN				JURE		(D	April	27	200	-	19:52 M
-	Examin	er	4a. Facility Name (If not institution, give str	11 . 1 .				Location of	t Death		40.	County of De	atn	
			5 Social Security Number 5. Sex	15 Hospital	lact hirthday	If Under	Itim	If Under 2	4 Hrs	9 Date of Birth		Q B	irtholac	e (State or Foreign
	Funeral		0.000	v 2□F 7. Age (117)/3.		Months	Days	Hours	Min.	8. Date of Birth (Month, Day Ceo 05	192	1	Country	MD MD
	Director		Usual Residence of Decedent			l				- 00				
	land		10a. State 10b. County		y, Town or Lo						.,		10d	. Inside City Limits
	Man,	ţ	MD Carrol	1	West	minst	er							1 ☐ Yes 2 ☐ No
	28a	rec	10e, Street and Number			10f. Zig	Code				10g. Citiz	en of What C	Country	?
	within 72 hours after death with the Maryland ene. Itan "neturel", or items 23a or 28a-f ehow the Modical Exercitor most be notified at	Funeral Director	344 Barnes Avenue				211	57				USA		
	deat	ner	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13.1	Was Dece	dent of Hi	spanic Orig	gin? (Spec	ofy Yes or No-	1	4. Race - An Black, Wh		
9	after or ite	3	1 Never Married 2 Married	1 ZÃYes 2 ☐ No If Yes, Give		1 ☐ Yes		Specify:	, 1 3011011	ilouri, oto.,		Specify:		nite
8	ours	d by	3 Widowed 4 Divorced	Year or Dates:				Openy.				Specity.		
ry O	72 h	Completed	15. Decedent's Educa (Specify only highest grade		16a. Dece (Give	kind of wo	rk done a	luring most	of workin	g	16b. Kin	nd of Busines	ss/Indus	stry
2	E 6 6	dr.	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT			2200	_	7\201	mdol (7027	oration
7	ygier rt.				ASSI	Starre	. Sal	es Ma		(First, Middle,			VI.	OLACION
밀	tai H d oth	Be	17. Father's Name (First, Middle, Last) Edward M. Curran							enney	Malden	sumame)		
<u>\S</u>	ould Mer Marke	2			1 .0		(2)				. 0.	T C4-4-	7:- 0	
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Important: if team 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	8 1	19a. Informant's Name/Relationship (Type Anna Curran/wife	e, Print)		ng Addres: Ba rn e		enue	west	Route Numbe tminste	r, City or Er, M	$\stackrel{\text{\tiny Fown, State}}{\mathbb{D}}$	157	ode)
d)	and fealth om 27			20h F	Place of Dispo					ate		cation - City of	or Town	State
Baltimore,	t of t		20a. Method of Disposition 1	moval from State	emetery, crei	matory or	other place	a) [/2006				
Ë	Per tant: jury		4 Donation 5 Other (Specify)		w Cath									,
3a	ermit eper npor ny in		21. Signature of Funeral Service Licenses							e and C				
	40 F • 0		Just Wa							d West		ter, N	1	21157
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not ent	ter the mo	de of dying	g, such as o	cardiac or	respiratory ari	rest,		l In	pproximate iterval Between inset and Death
1	Physician		Immediate Cause (Final disease or condition	Stroke									to	,
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	р ≡	ine	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):									
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for an a second					_				-	
90	cate be executed by sicien and the burial-transit	E		Due to (or as a conseq	derice or).									
8760,	death certificate be executed e ettending physicien and nd for use as the burial-transit	dicai	d.										+	
×	eath certific ettending p I for use as	Me	IF FEMALE:	a li una sutcama al pragn										
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 Live birth 2 Feta	Ideath 3	Ectopic p					2	3d. Date of d Month	delivery Di	ay Year
<u>.</u>	eb en the e	18	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of a 9☐Unknown	eath 5	Other (s	оөспу)							
P.O.	The law requires that the de- ste has been signed by the e- bage 2 should be detached f	Completed by Physician/Me	Part II. Other significant conditions conti	obuting to death but not res	ulting in the u	ınderivina	rause dive	en in Part I		23e. Did to	bacco us	se contribute	to the	cause of death?
JS,	iw requires that s been signed b should be det	þ	atrial flutter		g		, a a a a a a a a a a a a a a a a a a a				es 2[ly 4 □Unknown
5	regu been houk	etec	MA IN TOTAL					_		-				
ec	The law sate has t page 2 s	du								24a. Was a autop		prior to death	autops o comp	y findings available letion of cause of
<u>=</u>		ဒ									2 No		es 2	□ No
Division of Vital Record	Physicien: Th rthis certificate rai director, pag	Be	25. Was case referred to medical examiner?	ospital:			Oth	25		(Check only or				
of	this a	2	TIL Yes 205-NO	175Unpatient 2	ER/Outpatier			4 🗆 1401		se 5 Resid			oecify)	
Ľ.	After uner	o	27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	м	28c. Injury Work	γαι ∢? Yes 2∐h		ad. Describe n	iow injury	occurred		
Sic	Attending For death.	cat	2 Accident investigation 3 Suicide 6 Could not be	20 a Bloom of Injury. At h				162 Z 🗆 I		8f. Location (S	Strant and	A Number or	Dum I G	Pouto Number
<u>≥</u>	s after en Direct	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	y)	reet, lactor	у, опісе		-	City or Tow	m, State)	Tradition of	ribiarr	oute (vuiliber,
	e Hospital or Attending Physic 24 hours after death. e Funerel Director: After this ce lielely filled in by the funeral dire		29a. Certifier 15 Certifying Physi	ciant To the heat of my tra-	wieden de-	h occurre	at the to-	na date an	d place =	nd due to the	namen(n)	and masses	26 6101	ad .
	Hospita 24 hours Funera	edical		cian: To the best of my known: On the basis of examination and manner stated.										
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and marrier states.		29	c. License	number			29d. Date	signed (Mo	nth, Da	y, Year)
			MICHAEZ LEVY	/ MD		D	ES-	044				27,		
	WIL				- 026\ (7			FFF			7	- ' /		
	10		30. Name and address of person who con MICHAEL LEVY 600				P	AITIM	DAL	MARY	LANI	0 7	128	7
	C.	ate	Of Date Blad (Menth On March	OO Desidente Ciere				10/1/	3. 20	((() () () ()	-07/4/			*
	Regist		MAY 0 1 2	.006 Helice	M.	home	1.							

Med

Kevir

2812			Please Typ						
n Ashely Ca			e of Maryland / I				tal Hygiene	20	ne lete
		1- For State Registrar			ate of Dea	tn	2. Date of Dea	eg. No. 4U	00 1010
Pħysicia lical Exami			ely Carper	ey Carpei iter		T	Month April 25, 2	Day Year 2006	3 Time of Death 2110 hrs
		4a. Facility Name (if not institution, 9895 Gunston Road	give street and number)			Town, or Location of come	or Death	4c. County of Do	eath
Funeral		5. 2016 Security Number 6.	Sex 7. Age (In yrs. last birt	hday) If Und	der 1 Year If Unde		rth(MM/DD/YYYY) g.	
Director			X _{M 2} F	25	Yrs. Mont	hs Days Hours	Septembe	r 1,1980	Country) Marylan
any		10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
and show	P	MD Char	les	Port	Tobac	со			1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		_	1	p Code	1	log. Citizen of What (country?
th the 23a or notifie	Ö	7370 Simms L				20677		USA	
death wi	Funeral	11. Marital Status 1 X Never Married 2 Marri	12. Was Decedent Evi ied Armed Forces?	_			gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Ar White, et	merican Indian, Black, c.
fter de			1 Yes 2 Yebed If Yes, Give Year	₹ No	1 Yes 2	2 X No specify		Specify: W	hite
5-0036 led within 72 hours after death with the Maryland Aygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	d by	15. Decedent's Education (Specify	only highest grade compl			Occupation (Give		16b. Kind of Busine	
36 thin 72 h te than "n edical E	olete	Elementary/Secondary (0-12)	College (1-4 or 5+))			add retired)	Car	1 .
5-003 led withir Hygiene other th	Completed	17. Father's Name (First, Middle, La	2		Mechan		's Name (First, Middle,		rship
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	Be C	Francis J. C	·				hryn A. B	•	
Mer man	To	19a. Informant's Name/Relationship							tate, Zip Co g e 0 6 7 7
e, MD I and 2 sho Health and item 27 is r traumatic		Kathryn Carpe	nter/Mothe				ding Rd.	Port Tob	
		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	cremat	of Disposition (Na ory or other place	e)			
Baltimore, permit Pages I an Department of Her Important: If ite		4 Donation 5 Other Spec				Echols			te Hall,MD
Bal permi Depar Impo inijur		110:1051	1) mood				ÖLS FUNER		
Physician		23a. Part I. Enter the disease, or co		e death. Do no	ot enter the mode	of dying, such as o	Y S AVE ardiac or respiratory an	rest, shock, or heart	
/Medical		failure. List only one cause or Immediate Cause (Final disease	a. Multiple Injuries						Between Onset and Death
Adminer		or condition resulting in death)	Due to (or as a consequ	uence of):					
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):	,				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C.						
ecuted and - transit	Exa	events resulting in death) Last	Due to (or as a consequent	uence or).					
alal	dical	UNPENDED	X AMENDED iter	m#1,perM	E,g855,5/2	26/06 TT 5 F	er fh g855	5-30-06vt	:
Box 68760, e death certificate be the attending physicied for use as the buri	ian/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome			2		23d. Date of deli	
x 68 h certif tending use as	()	past 12 months?	1 Live birth 4 Pregnant at tire	me of death			c pregnancy	Month	Day Year
er e a	Physic	1 Yes 2 No 9 Unkno	9 Unkriown				Tax ave		
tal Records, P.O. Box 68760, rian: The law requires that the death certificate be certificate has been signed by the attending physici ector, page 2 should be detached for use as the burn	þ	Part II. Other significant condition	ns contributing to death b	out not resulting	g in the underlyir	ng cause given in Pa	23e. Did t		e to the cause of death? Probably 4 Unknown
of Vital Records, g Physician: The law require the certificate has been si meral director, page 2 should b	Completed	_					24a. Was auto		e autopsy findings available to completion of cause of
Reco The law cate has	omp							ormed? deat	h?
Vital R ysician: 1 his certific director, p	Be C	25. Was case referred to medical examiner?				26 Place of Death	(Check only one)		
of Vit ing Physic After this c uneral dire	To	1 ✓ Yes 2 No	Hospital: 1 Inpatient			DOA Other	Nursing Home 5	Residence 6 🗸 0	ther: Scene
n of ding Ph h After funeral	cation:	27. Manner of Death 1 Natural 5 Pendin	28a Date of Injury (Month Day Yea Apr 25, 2006	28b. 2052	Time of Injury 2 hrs	28c. Injury at Work	 Operator m 	how injury occurred otorcycle collision	on
Division tal or Attendi rs after death al Director: /	icati	2 Accident Investig	gation	rv - At home, fa	arm. street. factor	ry, office building, e		Street and Number of	r Rural Route Number, City
Division spital or Attenc hours after death neral Director:	ertifi	3 Suicide 6 Could redeterm	not be			,,,	or Town,		
를 수 를 등	O	29a. Certifier 1 Certifying Physics	sician: To the best of my l						
To the Hos within 24 h To the Fur completely	Medical	2	iner: On the basis of examination and manner stated	nation and/or i			ccurred at the time, date		
	Σ	29b. Signature and title of certifier	. 000		29	9c. License number O.C.M.E.		29d. Date signed	
		tal him	un-tolle	lus		O.O.IVI.E.		April 26, 2006	
DB is		30. Name and address of person w Patricia Aronica-Pollak	·	ath (Item 23a) edical Exam	niner 111 F	Penn Street, Ba	altimore, MD 2120)1	
	tate	31. Date filed (Month, Pax Year)	32. Fegistrar's	Signature	Sports	,			
Regis	trar	APR 2 8	2006 therees	15	The state of the state of				

DHMH 17 Rev 1/2001 OCME 2006

			4 101	eartment of Health and Mertificate of Death		iene _{eg. No.} 2006 15162
	Physici /Medic		Decedent's Name (First, Middle, Last) CAROLE ANN CHAMPAGNE		2. Date of Dea Month APRIL	th Day Year 2006 8:30A M
	Examin		4a. Facility Name (If not institution, give street and number) 17213 WHITES RD. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death POOLESVILLE If Under 1 Year If Under 24 Hrs.	0.000 - 4.00	4c. County of Death MONTGOMERY
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 5 9 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day) JULY 3	Year) Country)
Marylano	a-f ehow	ctor	MD MONTGOMERY POOLES			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
with the	Nor 28	Dire	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country?
within 72 hours after death with the Maryland	di tytyjene. id other then "naturel", or liems 23e or 28e-f ehov event, the Medicel Examinar must be notified at	by Funeral Director	17213 WHITES RD. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: WHITEE
within 72 hour	ene. then "natural he Medical E	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) VICE REPRESENTIV	ng S	WHITE 16b. Kind of Business/Industry SPRINT PHONE SERVICE
be filed	Mental Hygi arked other atic event, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name		
E 5	nd Mental Hygiene. marked other then imatic event, tra Mi	To	NORMAN WILLIAM CHAMPAGNE			EN SELDEN
0	27 is			ing Address <i>(Street</i> and Number or Rural 13 WHITES RD., E		
Pages 1 a	nent of Mee int: if item iry or othe		I Duna 2 Dicremation 3 Demoval from State I	osition (Name of Dismatory or other place) ICK CREMAT . 5/4/		20c. Location - City or Town, State FREDERICK, MD
permit. Pages	Department of Himportant: If Ite any injury or ott once.		► 111/ O.L.11	2. Name and Address of Facility HILTON FUNERAL H P.O. BOX 86, BAR	OMF NESVII	JE, MD 20838
Ph	ysician		23a. Fart1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition RESPIRATORY FA.	iter the mode of dying, such as cardiac or	respiratory arre	Approximate Interval Between Onset and Death
	physicien and sthe buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	B CELL NON-HODGK	INS LY	УМРНОМА
the death certifi	ed by the attending p detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
quires that	s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the operation of the part II. DIABETES MELLITUS	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
The law re	ete hes bee page 2 sho	Completed	HYPERTENSION, HYPOTHYROID DEPRESSION		24a. Was an autops perform	y prior to completion of cause of
VILCA iclan:	ector,	Be	25. Was case referred to medical examples? Hospital: Hospital:	26. Place of Death		
ding Phys	n. After this funeral di	tlon: To	1			nce 6 □Other (<i>Specify</i>) w injury occurred
To the Hospital or Attending	winn 24 mous arter doesn. To the Funerei Director: Atter this certificate hes completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		8f. Location (Sti City or Town	reet and Number or Rural Route Number, , State)
ne Hospit	n 24 nour	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and openion, death occurre	nd due to the ca d at the time, da	tuse(s) and manner as stated. ate and place, and due to the cause(s)
Tot	Tot	Σ	29b. Signature and title of certifier	29c. License number	29	ed. Date signed (Month, Day, Year)
F			30. Name and address of person who completed cause of death (Item 23a) (Type, MALINI MEESARAPU, MD 15201 SHAD	D 006 2044 OY GROVE RD., RO	CKVTTT	7/28/06 E, MD 20850
	Sta Registr	_	31. Date filed (Month, Day, Year) AY 0 1 2006 33 Registrar's Signature	ach)	CIVA TITI	L, LU 20030

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 2:50 P M April 2006 Linda Elizabeth Champion /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Atria Manresa If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🔀 F Yrs. 82 379-18-5786 Jan. 17, 1924 Michigan Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many events. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Annapolis 1 ☐ Yes 2X No Anne Arundel Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21401 85 Manresa Road #315 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White If Yes. Give Specify: þ 3 X Widowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Insurance 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Euna Lucille Wheat Thomas Montgomery ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 307 Fairhaven Road Tracy's Landing, MD Melissa Kangas/granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition Holy Sepulchre Cemetery 4/26/2006 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Southfield, Michigan 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses · Michel 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator **Physician** /Medical Due to (or as a consequence of): Examiner Ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of) Examiner Diease the attending physicien and hed for use as the burial-transit law requires that the death certificate be executed Comman Years Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. D 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1455 ister 1 ☐ Yes 2 → Nõ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00025499 moren unu 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 1460 itchie MO 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

7			1 - State 5-10-06 Registrar Amend#1.#19a.F		•				R	leg. No.	006	15161
	Physici /Medic		1. Decedent's Name (First, Middle, Last,	PEE EDDI	E LE		UPREE		2. Date of Dea Month	Day	2006	3. Time of Death
	Examir Funeral	ier	4a. Facility Name (If not institution, give MONTGOMEN 6. Set 5. Social Security Number 6. Set	TENERAL HOSP 7. Age (In yrs.	last birthday)	4b. City, If Under Months	Town, or Location of DLNEY 1 Year If Under 2 Days Hours	24 Hrs. 8	B. Date of Birth (Month, Day	Year)	Cou	MERY place (State or Foreign ntry)
W.	Director		Usual Residence of Decedent	5	O Yrs.							h Carolina
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-1 show sqical Ezani ret mus be i culfied at	Director	10a. State 10b. County Maryland Prince 10e. Street and Number		ty, Town or Lo	10f. Zip	Landove	r		IOg Citize	en of What Cou	10d. Inside City Limits 1 X Yes 2 No
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2	after death or items 2	y Funerai	11. Marital Status 1∰ Never Married 2 Married	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give		Was Deced f Yes, spec 1 ☐ Yes	dent of Hispanic Orig offy Cuban, Mexican		ify Yes or No- ican, etc.)	14	4. Race - Ameri Black, White,	can Indian,
0000-01	72	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grad	Year or Dates: cation e completed)	16a. Deced	dent's Usua	al Occupation	of working	,		d of Business/In	
7	filed within Hygiene. Ither than "	mo;	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Se	curity				Priv	ate
3	be file tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)					r's Name (First, Middle,	Maiden S		
yıaı	should to	2	James Du	<u> </u>					Magno			
2	7 10		19a. Informant's Name/Relationship (Type DENNIS RAY DUPRE James R. Dupree,	SR. /Brother			(Street and Number					748
בי בי	Pages 1 and ment of Health tant: if item 27 jury or other ti		20a. Mathod of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. I demoval from State	Place of Dispo cemetery, cren	sition (Nar natory or o	ne of	Da	te	20c. Loc	ation - City or T	own, State
	permit. Pa Depertmen Important: any injury once.		21. Signature of Funeral Service Licens			. Name an	of Address of Facility Of Bennin	y St	ewart	Fune	andover ral Hom ., DC	•
	Physician		23a. Part1. Enter the disease, or compl shock, or lear failure. List only of Immediate Cau e (Final disease or condition				le of dying, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
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.O. POV .O.	the death certific by the attending p ached for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3	Ectopic pr				23	d. Date of delive	ery Day Year
colds, r	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying c	ause given in Part I.		1	bacco use es 2 🗆		he cause of death? bably 4 Unknown
	The law ate has b page 2 si	Completed							24a. Was a autops perform	SV	24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of 2 No
VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				ol Death (Check only or	10)		
5	ding Phys h. After this funeral di	tion; To	1 Yes 2 XNo 27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Other: 4 Nur 18c. Injury at Work? 1 Yes 2 N	28	5 Reside		Other (Special Control occurred	fy)
		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre fy)	eet, factory	, office	28	f. Location (Si City or Town	treet and n, State)	Number or Rura	al Route Number,
	o the Hospital or thin 24 hours after the Funeral Dis impletely filled in	Medical C	29a. Certifier N☑ Certifying Phy: (Check only one) 1☑ Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation	, in my opinion, deatl	d place, an	d due to the c at the time, d	ause(s) a ate and p	nd manner as s lace, and due to	stated. o the cause(s)
	To the h within 24 To the F	Σ	29b. Signature and title of certifier	the Court	CT		License number	,	2	9d. Date	signed (Month,	Day, Year)
D	[3]		30. Name and address of person who co	impleted cause of death (Iter	n 23a) (Type,	Print)	166636		, , , , ,	1~~	71, CT	706
1	Sta	to	SUNIA HOLMES, H 31. Date liled (Month, Day, Year)	1.D. BIOL PR	INCE P	HIUP	DKIVE,	DINE	Y MAI	4/1	ND 2	20832
	Registi		MAY 0 3 2006	2. Registrar's Signa	from	Es .						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** MAY 01, 2006 11:58A ANNIE MARIE DOUGLAS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES BRADFORD OAKS NURSING AND REHAB CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Hours 1 M 20XF Months Director 1926 SOUTH CAROLINA 579 30 8410 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County ir than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at XXYes 2 No Directo PRINCE GEORGES CLINTON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 7520 SURRATTS ROAD 20735 Completed by Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 Widowed XX Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2+ REGISTERED NURSE GOVERNMENT .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 Is markad other t jury or othar traumatic evant, ID other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KATIE (UNKNOWN) JASPER DIXON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OXON HILL, MD 20745 PAULETTE NIELSON / DAUGHTER 4607 WHEELER RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State permit, Page Department of important: If any injury or once. METROPOLITAN CREMATORY 5/8/2006 ALEXANDRIA, VA ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ALZHEIMER'S DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ ag Pe 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Division of Vital Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: XX Nursing Home 5 Residence 6 Other (Specify) 2XXNo 3□ DOA 2 1 ☐ Yes 2 ER/Outpatient this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1XXVatural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 | Homicide ò To the Hospital o within 24 hours af To the Funeral D 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier Don D35206 MAY 02, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 LIVINGSTON ROAD FORT WASHINGTON, MD 20744 WILLIAM TANNER, MD 2. Registrar's Signature 31. Date filed (Month. Day. Year) State Registrar MAY 0 3 2006

State of Maryland / Department of Health and Mental Hygiene

			Amend #5 Per FH	G85 <u>6</u> 6/06	/06 JH <i>Cei</i>	rtificate o	f Death		Reg. No.	Ub	10100
			1. Decedent's Name (First, Middle, Last,)				2. Date of I	Death Day	Year	3. Time of Death
	Physici /Medio		Henry DeMatteis					APRI	L 25 2	2006	3:05 PN
	Examir		4a Facility Name (If not institution, give	street and number)			4b. City, Town	n, or Location of Dec	ath 4c. County	of Death	
			FutureCare Chesa	apeake			Δ.	rnold	Ar	no Ar	nndol
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday)	If Under 1 Yea	ar If Under 24	Hrs. 8. Date of 8	Birth Dey, Yeer)	9. Birthp	rundel lace (State or Foreign try)
	Director		059-16-7832	1 M 2□ F	84 Yrs.	WOTKITS DOY	3 110013		8, 1921	0007	NY
	P	'	Usual Residence of Decedent								
	anylen show		10a. State 10b. County MD Anne Ar	nmdol .	10c. City, Town or Lo					,	Od. Inside City Limits
	the Ma	cto	Alle Al	under		Anna	polis				1 ☐ Yes 2 🙀 No
	within 72 hours after death with the Marylend ane. then "netural", or Hems 23a or 28a-f show the Medical Exacitee mast be notified at	Funeral Director	10e. Street and Number			10f. Zip Code	•		10g. Citizen of	What Coun	try?
	23a	- E	943 Starfish Court	<u> </u>			21401			USA	
	E B	ne l	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U,S. 13.1	Was Decedent of If Yes, specify Cu	f Hispanic Origin Johan, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	No- 14. Rad Bla	ce - Americ	
0	afte or m	F	1 ☐ Never Married 2 ☐ Married	1 🔀 Yes 2 🗌 N If Yes, Give	wii	1 □ Yes 2 🐼 N				y: Whi	
000	iral',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	******						
5-(72 ho	Completed	15. Decedent's Edu (Specify onfy highest gred	cation e <i>completed)</i>	16a. Deced	dent's Usual Occ kind of work don DO NOT use reti	upetion le during most d	of working	16b. Kind of B	usiness/Inc	dustry
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2		S	12			Presse	_	- Na (First Add	Bond		ing
ū	be filed tal Hyg d other event,	Be	17. Father's Name (First, Middle, Lest)				18. Mothers	s Name (First, Midd	ile, Maiden Sumer	ne)	
yla		၉	Emil DeMatteis					Bridggia			
Maryland 21215-0020	0, 00 00 5	- 1	19a. Informant's Name/Relationship (Ty					or Rural Route Nurr		, State, Zip	Code)
	C # 20 F		Louis Cecehini/Ne	phew	COTTON CONTRACTOR		rive, H	ughesvill	T	0637	
ore	Se to L		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ R	Removal from State		natory or other p		Date Apr 27	20c. Location		
Ē	nit. Pag artment ortant: I injury c		4 ☐ Donation 5 ☐ Other (Specify)		Metro	Cremato	ory	Apr. 27 2006	' Balti	more,	MD
Baltimore,	permit. Page Department of Important: If any injury of		21. Signature of Funeral Service License	ee //	12	a irranco	res of acility	, P.A. Se	verna Pa	rk Fu	neral Home
m	8258		Alham. 5 V	1/1/2	4	95 Gov.	Ritchie	e Hwy, Se	verna Pa	rk, M	neral Home D 21146
			23a. Part1. Enter the disease, or compli	cations that caused	the death. Do not ent						Approximate Interval Between
	Physician		shock, or heart failure. List only or	ne cause on each lin	е.					april April	Onset and Death
	/Medical		Immediate Cause (Final	ENIN CT	ALE NULL	1763	c 1-1 N 10	my - AA	7114	and and	
	Examiner		disease or condition resulting in death)		AGE DILA Due to (or as a conseq		Chresie	STITUTY	171		
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	certificate be executed iding physician and use as the buriel-transit	Examiner			Due to (or es a conseq		D'01-17	> <u>-</u>			
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B	requires that the death seen signed by the atter hould be detached for t	Physicia	Part II. Other significent conditions con	tributing to death bu	t not resulting in the u	nderlying cause o	given in Part I.	23b. Di	d tobacco use co	ntribute to	the cause of deeth?
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ĕ	quire; n sig uld b	8						24a. Wa	as en eutopsy rformed?	24b. We	re autopsy findings
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Re	The law ate has to page 2 s	Completed							You at No]Yes 2□ No
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of	Phys rthis raidi	<u>۽</u>	27. Manner of Death	28a. Date of Injur	v 28b. Time of				e how injury occur		9
on	ding h. After	후	1 Natural 5 ☐ Pending	(Month, Dey	Year) Injury		lork? ∐Yes 2∐No	,			
:0	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, farm, str				(Street and Numb	per or Rure	Route Number,
Division of Vital Records,	after Direction by	Certification:	4 ☐ Homicide determined	building, etc					own, Stare)		
_	pital ours eral filled	0	29a. Certifier 10X Certifying Phys	sicien: To the hest o	f my knowledge, death	occurred at the	time date and r	place, and due to th	e ceuse(s) and ma	anner as st	eted.
	Hos 24 h Fun etely	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner state	examination end/or inv	estigation, in my	opinion, death	occurred at the time	e, date and place,	and due to	the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	N N	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month, l	Day, Yeer)
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			30. Name and address of person who co	ompleted cause of de	Talli (Helli 23a) (Type,	Print)	111111	111- 1	140 0	4- 6	
	Sta		30. Name and address of person who co	B60 VCC 32/Registra	eath (Item 23a) (Type,	My M	Lillersn	rille, 1	U) 2	1108	

		For State Registrar			Mental Hygier	ne 2006	1516
Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last William LeRoy 4a. Facility Name (If not institution, give Montgomery Gener	Darby, Jr.	4b. City, Town, or Location of Death	April 2	Day Year 8 2006 4c. County of Death Montgome	3. Time of Death 13:33
Funeral Director		Social Security Number 6. Se		/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Birth Cou 1925 Vi	place (State or Foreign ntry) rginia
ne Maryland 8a-f ehow	Director	Md. 10b. County Md. Montg	omery 10c. City, Town or Silve	er Spring			10d. Inside City Limits 1 ☐ Yes 2 X No
h with th	ai Dire	10e. Street and Number 14801 Pennfield	Circle, #409	10f. Zip Code 20906	109.	Citizen of What Cou United S	
d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. 77 is marked other then "neturel", or iteme 23s or 28s-f show traumatic event, Its Madical Exercites mast be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Pes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: W	
within 72 horene. ene. then "neture	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of wo. DO NOT use retired)	rking	. Kind of Business/Ir Grocery S	
illed I Hygi other	To Be Co	17. Father's Name (First, Middle, Last) William LeRoy	Darby, Sr.	18. Mother's Nar Laura	me (First, Middle, Maid Allnutt	den Sumame)	
nd 2 sho lith and 27 is ma		19a. Informant's Name/Relationship (Ty William L. Darby		iling Address (Street and Number or Ai 7 Rutland Road, Da			o Code) 1035
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury occiper traumatic over injury occiper traumatic once.		20a. Method of Disposition ↑☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	position (Name of ematory or other place) 7 Cemetery 5/		. Location - City or T eallsvill	
permit. Depertrimports eny inju		21. Signature of Funeral Service Licens **Murrief** H. /	Burker	22 Name and Address of Facility Muriel H. Barber P. O. Box 5038,			20882
Provided and American	cal Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused the death. Do not ene cause on each line. a. Stage Rule Stage Rule (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	eual Dispose ellitus			Approximate interval Between Onset and Death
The law requires that the death certifical are has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliving Month	rery Day Year
w requires that to be to be signed by should be detail	à	Part II. Other significant conditions or	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobace 1 ☐ Yes	co use contribute to	the cause of death? bably 4 □Unknow
: The law re cete has bee , page 2 sho	Completed				24a. Was an autopsy performed	prior to o death?	opsy findings available ompletion of cause of
Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner?	Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Other	ath (Check only one) Home 5 Residence	e 6 □Other (Spec	(fy)
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: T	27. Manner of Death Platural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time Injur	of y 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	njury occurred	
To the Hospital or Attending Physicien: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be		4 Homicide determined 29a. Certifier Certifying Ph	building, etc. (Specify) ysician: To the best of my knowledge, de	eath occurred at the time, date and place	City or Town, S	e(s) and manner as	stated.
the Ho nin 24 h the Full apletely	fedical	(Check only 2 Medical Exam	iner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, date	and place, and due	to the cause(s)
P + 1	2	29b. Signature and title if dertifier	my	29c. License number 29c. License number	29d.	Date signed (Month	Cay, rear)
S Regis	tate	30. Name and address of person who of the state of person who of the state of person who of the state of person who of the state of person who of the state of person who of the state of t	completed cause of death (Item 23a) (Tyr	ee Milip Duva	· Olwer	MDE	20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Items 23a-d per doc 855 5-15-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Katherine B. Davenport April 8,2006 1:10 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7317 Judi Drive Bryans Road Charles 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√5√F Yrs 577-16-2874 Director Oct. 3,1918 Washington D.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene. ?7 ie marked other than "natural", or Itsms 23a or 28a-f shov traumatic event, the Nedical Examinar must be notified at 1 ☐ Yes 2 XNo Directo Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7317 Judi Drive 20616 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, the Medical Examples. Once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Blanchard Elliot Alice 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hal Clagett Son 7317 Judi Drive, Bryans Road, Md. 20616 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Charles Cemetery

Date

April 11,2006 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Indian Head, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20640 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease **Physician** /Medical Due to for as a consequence of): Examiner Cardiac Arrhytmias/HIN Sequentially 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Pulmonary HIN The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physicien Division of Vital Records, P.O. Box 68760 Chronic Bronchitis Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 14No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 L No 1 ☐ Yes 3 Probably 4 Unknown this certificete has been si ral director, page 2 should t Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was se referred to medical examiner? 1 ☐ Yes 2 ☐ No 1☐ Yes or Attending Physician: 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient No No Other: 4 Nursing Home Medical Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural Accident 5 Pending 1 ☐ Yes 2 No To the Hospital or Attandir within 24 hours efter death.
To the Funeral Director: A completely filled in by the fu death. investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 110/06 MOFIRE who completed cause of death (Item 23a) (Type, Print) Under Philip 13605 Badan Wist No. of Rand. Brandy MD 20613 31. Date filed (Month, Day, Year) State MAY 1 Registrar 5 2006

			1 - For State Registrar	State of M		partment of H ertificate of I			ene 2006	15169
	多 第 《	2.7	1. Decedent's Name (First, Midd	lie, Last)				Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		CALVIN	COOLIDGE	DAVIS				28 2006	6.13 a M
	Examir		4a. Facility Name (If not institution	on, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Death	
			Frederick Men	norial Hospit	al	Fred	lerick		Frederi	ck
* ** ***	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthda			8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign intry)
20 mg	Director		722-18-5675	1 2 M 2 □ F	78 Yrs.	Worldis Days	Flours Will.	Oct. 9,	1927 Ma	ryland
-	p ,		Usual Residence of Decedent		40- Oit T					
	show dat	_	10a. State 10b. Count	/	10c. City, Town or	Location				10d. Inside City Limits
	8a-f	cto	MD (arroll	Mt.	Airy				1 ☐ Yes 2 ☐XNo
	Sr th	Oire	10e. Street and Number			10f. Zip Code		-	. Citizen of What Co	-
	23a	Funeral Director	2508 Flag Ma	irsh Koad		21	.771	U	nited Stat	es
	r deg	ne	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 1	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or li	by Fu	1 Never Married 2 Ma	If Yes, Give	ì	1 ☐ Yes 2 🛣 No	Specify:		Specify: [7]	ite
215-0036	72 hours after death with the Maryland natural', or Itame 23a or 28a-f show dishi Examirat must bu modified at	d b	3 Widowed 4 Divorce		1970				VVI	
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121	Hygie Hygie ther ant, II		12 17. Father's Name (First, Middle	(ast)		ALIIIY	18. Mother's Name		US Armed :	rorces
and	ntal h	Be		el G. Davis						·-
Ž	should nd Men marke umatic	To	19a, Informant's Name/Relation		19b Ma	iling Address (Street a		R. Woods		in Code)
Maryland	12 s h an 7 ls r traur			Wife						p Code)
	1 an Heall am 2 ther		Betty Davis 20a. Method of Disposition	MILE	20b. Place of Dis	508 Flag M	. D:		CY, MD ZI	//I
ō	in it of or o		1 X Burial 2 ☐ Cremation		Poplar	prings Cel			Poplar Spr	
tin	t. Partitude		4 Donation 5 Other (-					
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Itame 23a or 28a-f show mith journer in the Traumatic event, The Medical Examination and Partmet in the Iran Medical Examination of Pages.		21. Signature of Funeral Service	Ucensee	1	22. Name and Addres Burrier-Qu	een Funera	al Home &	& Cremator	v. PA
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	/Medical Examiner		Joseph Jan Godin,	Due to (or as	a consequence of):		0 10 10			111
y.			Sequentially list conditions,	b	a consequence of):	200	ON W	7]		110
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4 iATA		(· _			271.0
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o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	t time of death	☐ Other (specify)				
Δ.	hat II ad by detac	Ph	Part II. Other significant condit	ions contributing to death b	out not resulting in the	underking cause give	en in Part I	23e. Did tobac	cco use contribute to	the cause of death?
Records,	sign a pe	1 by	1 nother	c Card	0 0 000 00	in th		1 ☐ Yes		bably 4 □Unknown
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}ec	e law	npi	- My Na	e wo	ff wer	3		24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
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ū	After uner	on:	27. Manner of Death 1 Natural 5 □ Pend		y Year) 28b. Time Injury	Worl		8d. Describe how	injury occurred	
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Division	or At fter c Direc in by	Certification:		mined 28e. Place of In building, e	ury - At home, farm, c. (Specify)	street, factory, office	2	8t. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	pital ours a sral [29a. Certifier Certify	as Physician T	of much much to the	-Ab				
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عا	AVITA		30. Name and address of person	wno completed cause of	leath (Item 23a) (Typ	11.	1		C-1.	O nail
d.		ate	31. Date filed (Month, Day, Yea	32 Bhoist	ar's Signature	1 100mi	Mpof Ca	s) en m	. trear	ele ives
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			1 - For Amend Item	State of Ma per FH, G	aryland / De 855,05/16	partment of F 706dhb	lealth and	Mental Hy	gien	2006	15170
		7	Decedent's Name (First, Middle, La			ortinoate or	Death	2. Date of De	aath		3. Time of Death
	Physici		Rov	Car1	. Earles	3		Month	8, ^{Da}	2006	2225 P M
1	/Medi Examir		4a. Facility Name (If not institution, giv		Burre		r Location of Deat			. County of Death	2223 1
4	16. 16.	<i>(</i> *	27 Woods Way			E1k	ton			Ceci1	
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs		th		lace (State or Foreign
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	pu		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Lacation					
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	he M	ecto	10e. Street and Number		EIKLOI						
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	her d	ä	1 Never Married 2 Married	Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.))-	Black, White,	
336	urs af	b	3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ N If Yes, Give Year or Dates:	1945-	1 ☐ Yes 2X No	Specify:			Specify: Whi	te
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b	be filed tal Hygie d other event, th	Be	17. Father's Name (First, Middle, Last,					me (First, Middle			
<u>a</u>	Mental Merked o	To	Carl Brown Earle	S			Aı	nma Aman	da F	ckle	
Maryland	and and and and and and and and and and		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Ri	ural Route Numb	er, City	or Town, State, Zip	Code)
	1 and 2 Health Iem 27		Brenda Nichols,	Daughter	428	Big Elk (Chapel Re	oad, Elk	ton.	MD 2192	1
Baltimore,	0 0 == =		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dis	position (Name of rematory or other place	Carried Assets	Date	20c. L	ocation - City or To	wn, State
Ē	permit. Pag Department Important: I any Injury o		4 Donation 5 ☐ Other (Specif		Cherry Hil	11 Methodist	Cem. May	12, 2006	Cher	rry Hill.	MD
at	permit. Par Department Important: any injury		21. Signatu e of Funeral Service Licer	isee		22 Name and Address Hicks Home	s of Facility	erale 1	PΛ	.,,	
-	2029		1 Daniel S	Huko		103 W. Sto	ockton St	Elkt	on.	MD_ 2192	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not e	enter the mode of dyin	g, such as cardia	or respiratory a	rrest,		Approximate Interval Between
最	Physician		Immediate Cause (Final disease or condition	CANO	EN OF	THE L	426-8				Onset and Death
1	/Medical		resulting in death)	Due to (or as	consequence of):						
100	Examiner		Sequentially list conditions.			THIS PIE	COSTATION	E CUT	ND		YEAR
7	p ij	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	a consequence of):						
1	and trans	Examin	that initiated events resulting in death) Last	c. Ctron	ne 0159 a consequence of):	Tructor	12 pun	NOWATEG	AL	SGASE	4 GAN
60,	be ex cian burial			•	, , , , , , , , , , , , , , , , , , , ,	20TIC CAT	one) " he	Claims	NE	10000	YRAN
68760	ficate be executed physician and is the burial-transit	edical	•	d. 100 1010	003000	conte cari	OBVVVIIS	Cappille	GUS	EAST (· VOMI
_	E 00.00		IF FEMALE:	23c. If yes, outcome	of pregnancy	-					
Вох	eath certif attending for use as	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	B Ectopic pregnancy				23d. Date of delive Month	ry Day Year
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a	that ed by deta		Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco i	use contribute to th	e cause of death?
of Vital Records,	uires sign ld be	d by			_	, , ,		101	Yes 2	□No 3□Proba	ably 4 Zunknown
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<u>ra</u>		e Co	25. Was case referred to medical					1 ☐ Yes	2/2 No		2 No
Ē	ici ee e	03	examiner?	Hospital:	a □ 50/0 · · ·	ont 3C DOA Othe	200	ath Check only o			
ō		. To	27. Manner of Death	28a. Date of Injur	nt 2 ER/Outpati	BILL SE BOX	4 🗆 Nursing n	28d. Describe		6 ☐ Other (Specify)
o	ding I th. : After s funer	ig ig	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		(? Yes 2 □ No		, , , , ,	,	
Division	or Attending after death. Director: After in by the funer	100	3 ☐ Suicide 6 ☐ Could not be	286. Place of Inju	ry - At home, farm,	street, factory, office		28f. Location (S	Street an	nd Number or Rural	Route Number.
Ö	al or after t Dire	Certification:	4 ☐ Homicide determined	building, etc	(Specify)			City or Tox	vn, State)	
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowledge, de	ath occurred at the tim	e, date and place	, and due to the	cause(s)	and manner as sta	ated.
	n 24 n 24 ne Fu	edical	(Check only 2 Medical Exam one)	niner: On the basis of and manner sta	examination and/or	investigation, in my op	ointon, death occu	rred at the time,	date and	place, and due to	the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. License	number		29d. Da	te signed (Month, L	Day, Year)
			Fulrall.	Gist.		200	7463		5	9-06	
	اارم		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	e, Print)				, - 1	
	211		Rolando A. Najer	a, M.D.	138 Cathe	dral Stree	et. Elkto	on. MD '	2192	1	
	Sta		31. Date filed (Month, Day, Year)		r's Signature	0-0-					
	Registr	ar	MAY 1 5 2	006 August	J. B. A.	09462					

	•	For State (of Maryland / Dep Ce	partment of Fertificate of			giene Reg. No.	6 5 7
Physicia		1. Decedent's Name (First, Middle, Last) Elmer Martin Edgingto	n			2. Date of Dea Month May 1,	th Pay Yea	3. Time of Death AM 12:05 ^M
/Medic Examin		4a. Fecility Name (If not institution, give street and not 16100 Pond Meadow Land	ımber)	Bowie			4c. County of De Prince C	eath
Funeral Director		5. Social Security Number 194–18–0745 Usual Residence of Decedent	7. Age (In yrs, last birthda 82 Yrs,	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day NOV • 22	(, Year)	Birthplace (State or Foreign Country) Ladelphia, PA
Maryland e-f ehow	tor	10a. State 10b. County Maryland Prince George	10c. City, Town or Bowie					10d. Inside City Limits 1X∑Yes 2 ☐ No
with the	i Director	10e. Street and Number 16100 Pond Meadow Lane		10f. Zip Code	20716		10g. Citizen of What USA	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Misportant: If tien 27 is marked other then "naturel", or items 23a or 28e-f show eny injury or other traumatic event, the Modical Extrainer matches notified at once.	by Funerai	Armed F	2 □ No ive	I. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)		merican Indian, hite, etc. White
vithin 72 hou ne. hen "nature	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College	16a. Dec	redent's Usual Occup ve kind of work done DO NOT use retire	during most of world)		16b. Kind of Busines (currency Bureau of	// stamps)
id be filed v fental Hygie rked other t fic event, III	To Be Co	12th 17. Father's Name (First, Middle, Last) Elmer Roy Edgington		Plate Pr	18. Mother's Nan		Maiden Sumame)	Ingraving
i, INICAL YICA and 2 should I ealth and Men n 27 is marke her traumatic		19a. Informant's Name/Relationship (Type, Print) Dennis L. Edgington /	Son 161	0 Pittsfi		Bowie,		5
mit. Pages 1 partment of He cortant: If Iter y injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from '4 □ Donation 5 □ Other (Specify)	MD Veter	rans Cemet	ery May	5, 2006	Cheltenha	
permit. Departri Importe eny injk		21. Signature of Funeral Service Licensee	a. 1004	22. Name and Address	5 5 1		neral Home D 20715	>
Physician Physic	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.	caused the death. Do not eleach line. Onic Obstruct (or as a consequence of): (or as a consequence of):				rest,	Approximate Interval Between Onset and Death Yr.
The law requires that the death certificate be example to the law requires that the death certificate be example to the second physician page 2 should be detached for use as the burial	Physician/Medical	in the past 12 months?	nant at time of death 5	B Ectopic pregnanc	у		23d. Date of o	delivery Day Year
requires that een signed b	þ	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause giv	ven in Part I.		_	lo the cause of death? Probably 4 □Unknown
The law re ate has bee page 2 sho	Completed					24a. Was a autops perfor	sy prior t med? death	autopsy findings available to completion of cause of ?
Physician: This certific	To Be	25. Was case referred to medical examiner? 1 Yes	Inpatient 2 ER/Outpati	ent 3 DOA	bar	th (Check only or	ence 6 Other (Sp	pecify)
ff figure		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		of 28c. Inju	ry at		ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Certification:	4 Homicide Scientifica built	e of Injury - At home, farm, ding, etc. (Specify)			City or Tow		
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1⊠ Certifying Physician: To the 2 Medicel Examiner: On the and ma 29b. Signature and title of certifier			opinion, death occu	rred at the time, d		lue to the cause(s)
7 (5)		30. Name and address of person who completed car	use of death (Item 23a) (Typ		9431		May 1, 2	.006
		Dr. Frank Ryan 117	01 Livingstor Registrar's Signature		Ft. Was	nington,	MD 20744	
Sta Registr			Hegistrar's Signature	arte				

		T = For State Ragistrar 1. Decedent's Name (First, Middle, Last)		Ce	artment of rtificate of		2. Date of Deat	eg. No.	3. Time of Death
Physic /Med		MARY G.	ESTEP-	- Kout	·H		Month Apr	26, 2006 Year	8:40 P
Exami		4a. Facility Name (If not institution, give s			4b. City, Town	n, or Location of De Dunkirk	əath	4c. County of Death	Arundel
Funera Director		5. Social Security Number 6. Sex 213-24-3826	7. Age (79 Yrs.	Months Da		lin. 8. Date of Birth (Month, Day, Sep 18,	9. Birtl 1926	nplace (State or Foreig untry) Maryland
Maryland -f ehow	tor	10a. State 10b. County MD Anne Ar		Oc. City, Town or L	ocation	Dunkirk			10d. Inside City Limit
with the 3a or 28a	Funeral Director	10e. Street and Number 135 Jewell Road			10f. Zip Cod	20754	1	og. Citizen of What Co	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show priprity or other traumatic event, it a Modical Examinal must be notified an once.	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of Yes, specify 0		(Specify Yes or No- lerto Rican, etc.)	14. Race - Amer Black, White Specify: Black	e, etc.
vithin 72 hande.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use re	ne during most of	working	16b. Kind of Business/I	•
nd 2 should be filed within 72 hours af ith and Mental Hygiene. 27 Is marked other than "natural", or r traumatic event, the Medical Expan	To Be Co	17. Father's Name (First, Middle, Last)	Edward Curtis		Ladila		Name (First, Middle, M		
and 2 shousalth and M		19a. Informant's Name/Relationship (Ty) Vaughn Estep/son	pe, Print)	19b. Mail 907 I	ng Address (Str Ben Jones	eet and Number or Lane Lothian	Rural Route Number, , MD 20711	City or Town, State, Z	ip Code)
permit. Pages 1 are population of Heal mportant: If item my injury or otherwise.		20a. Method of Disposition 1			osition (Name of matory or other of Church Cen	olace)	Date 2	20c. Location - City or 3 Friendsh	
permit. F Departm Importar eny injur		21. Signature of Funeral Service Licenses Place 4.	Sevel	1 2		dress of Facility Funeral Hon Pares Beach		rederick, MD 20	678
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a co	OSPA	GB.	RENA	L DIS	EASE	Approximate Interval Between Onset and Death
death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a of some of som	pregnancy □ Fetal death 3 (□Ectopic pregna			23d. Date of delin	very Day Year
res that the de signed by the a be detached t	by Physi	1 Yes 2 No 9 Unknown Part II. Other significant conditions con		not resulting in the o			23e. Did tob	acco use contribute to	the cause of death?
requir	Completed t	DIABLYES	TID	ITUS	- 146	E II	1 ☐ Ye	24b. Were aut	obably 4 Unknow
	a)	25. Was case referred to medical				26 Place of I	autops perform 1 Yes 2	ted? death? 1 ☐ Yes	ompletion of cause o
ysicii is cer direct	To B	avaminar?	lospital:	2 ER/Outpatie	nt 3 DOA	Other: 4 Nursing	• •	nce 6 ☐Other (Spec	ufy)
Attending Physician: r death. sctor: After this certifica by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (njury at Work? Yes 2 No	28d. Describe ho		
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. ((Specify)			City or Town	, , , , , , , , , , , , , , , , , , ,	
the Hosp nin 24 hou the Fune apletely file	Aedicai	(Check only 2 Medicel Examir one)	ner: On the basis of example and manner state	kamination and/or ind.	ivestigation, in m	ny opinion, death o	ccurred at the time, da	use(s) and manner as ite and place, and due	to the cause(s)
¥iti To To	Σ	29b. Signature and title of certifier	DR-Zo.	BEPH	290. Lic	56 /6 /	28	od, Date signed (Month 04 /27/6 MD 2) (ITHE
					0	20,07		1/2//0	(000

		For State Registrer		e of Maryla	nd / De _l		of Health	and M	lental Hy			6 5 7	13
	П	1. Decedent's Name (First, Midd	e, Last)						2. Date of De	ath		3. Time of Death	
Physicia /Medic		Calvin Ray Erv	in						Month 0 4	2 8			М
Examin		4a. Facility Name (If not institution		d number)		4b. City, To	wn, or Location	on ol Death			County of De		
		Peninsula leg	inal N	edical (enter	. 5	Wish	114			Wicon	210	
Funeral		5. Social Security Number	6. Sex 1 M 2 □	7. Age (In yr.	. last birthda		Year If Und	ler/24 Hrs.	8. Date of Bir (Month, Da	th		irthplace (State or Fore Country)	ign
Director		218-40-8614	1 1 M 2 L	63	Yrs.	MOTITIS	Days Hour	s Min.	June 28			ryland	
P .		Usual Residence of Decedent		100	Vie. 2"								
aryla ehov	Ļ	10a. State 10b. County		100.0	ity, Town or	Location						10d. Inside City Limi	
Ba-f	cto	Maryland Wicom	ico	He	bron						1 ☐ Yes 2 ☑ No		
or 2	Director	10e. Street and Number				10f. Zip C	ode			10g. Cit	izen of Whal C	Country?	
eth v		9133 Hummingbi	cd Ct.			2183				USA			
er de	Funeral	11. Marital Status	Ame	Decedent Ever in d Forces?	U.S. 13	 Was Deceder Yes, specify 	nt of Hispanic (Cuban, Mexic	Origin? (Specan, Puerto	ecify Yes or No Rican, etc.))-	 Race - Arr Black, Wh 		
s aft	by F	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes	es 2 □ No s, Give		1 🗆 Yes 2	XNo Speci	ify:			Specify:	71	
turai E E				or Dates: Arm	-						N	White	
"na"	Completed	(Specify only highs	l's Education st grade comple	ted)	16a. Dec	cedent's Usual of work . OO NOT use	Occupation done during m	ost of work	ing	16b. Ki	ind of Busines	s/Industry	
withi ane. than	m	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)		x Print				Б	rintin	~	
Hygie Ther nt, II	ဝိ	17. Father's Name (First, Middle,	(ast)		Verc	V LLTIII		ther's Name	e (First, Middle,			9	
od o	00									, Maldell	Sumamej		
d Me d Me mark matic	2	Calvin Ervin 19a. Informant's Name/Relations	hin (Tuna Print			Myers	0:						
d 2 s th an 7 ie r			100			iling Address (S						, Zip Code)	
1 an Heall em 2 ther		Kathleen Murre. 20a. Method of Disposition	II/SIST			Dagsb			.sbury, N			21804	_
or o	1	1 Burial 2 Cremation	3 □Removal f	rom State An	cemetery, ci	ematory or other	er place)] 		200. LC	cation - City o	or rown, State	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or items 23a or 28a-1 show any injury or other traumatic event, Its Micilial Examinar must be notified at once.		4 Donation 5 Other (S			egistr	У		4/28,	-	Hano	ver, Ma	ryland	
Department Department of the police.		21. Signature of Funeral Service	Licensee			13113W3\							
### G	Ц	23a. Part1. Enter the disease, o	my h (FSA	5	01 Snov	Hill	Rd. Sa	<u>alisbur</u>	y,Ma	ryland	21804	
Physician /Medical Examiner purial-transit	cai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	a b c	e to (or as a conse	quence of):	ular	Care	cino-	~~ a.			Interval Between Onset and Death	Le
ficate phys s the	edic												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 L 4 D	i, outcome of pregi ive birth 2 Te regnant at time of Inknown	tal death 3	B⊟Ectopic preg i⊟ Other <i>(spec</i>				1	23d. Date of de Month		
that	by P	Part II. Other significant conditi	ons contributing	to death but not re	sulting in the	underlying cau	se given in Pai	rt I.	23e. Did to	obacco u	se contribute	to the cause of death?	
puire n sig	D D								101	Yes 2	25 0 3 🗀 P	robably 4 Unknow	'n
w rec	lete								24a. Was	20	24h Wasa	ulangu findinas ausulah	ı.
siclan: The law certilicate has t irector, page 2 s	Completed			No.					autop		prior to death?	aulopsy findings available completion of cause of s 2 \sum No	10
iclan Sertif ector	Be	25. Was case referred to medica examiner?	-					ice of Death	Check only o	ne)			
this all dir	ို	1 ☐ Yes 2 No			☐ ER/Outpati			Nursing Hor	ne 5⊡Resid	dence (5 □Other (Sp	ecily)	
tending I eath. or: After the funer	Certification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	ig (gation	Date of Injury Month, Day Year)	28b. Time Injury	ol 280	. Injury at Work? 1 ☐ Yes 2 [28d. Describe I	now injur	y occurred		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		4 Homicide determ	nined 286. F	Place of Injury - At I ruilding, etc. <i>(Spec</i>	rify)				City or Tov	vn, State,)	Rural Route Number,	
the Hosp in 24 ho the Fune pletely fi	Medicai	one)	and	the best of my kr ne basis of examin manner stated.	iowledge, de lation and/or	ath occurred at investigation, in	the time, date my opinion, d	and place, a eath occurre	and due to the ed at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)	
To To	2	29b. Signature and title of certifie	//				icense numbe				•	oth, Day, Year)	
. ~		147/	and "	McO.		5	3069	ن خ		Agr	.1 28	3,006	
12.6		30. Name and address of person				. ,							
101		James E. M4	AT, N	M.O. /	450	- Ger	11 57	5-	1:55		np ;	1001	
Stat Registra		31. Date filed (Month, Day, Year)	1 3	2. Registrar's Sign	nature	1		/					

DHMH 17 Rev 1/2001

H198 0 8/72

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ERVIN, CalVIN

		-	For State Registrar	State of	Maryland /	•	artment <i>rtificate</i>					jiene _{eg. No.} 2	06	15174
			1. Decedent's Name (First, Middle	e, Last)			_			2.	Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic	al	CHARLES ROBERT								APRIL		2006	4:30P M
	Examin		4a. Facility Name (If not institution				4b. City, T						ty of Death	
			ST. THOMAS MOO		Age (In yrs. last	hirthday	If Under 1		If Under		Date of Birth		7-	EORGES place (State or Foreign
	Funeral Director		5. Social Security Number 256 26 6013	6. Sex XX M 2□F	83	Yrs.		Days	Hours	Min.	(Month, Day PR. 12	, Year)	Cou	RGIA
			Usual Residence of Decedent		0_			1		jA1	. 1.	, 1723	OLO	KOIN
	yland		10a. State 10b. County		10c. City, To	own or L	ocation							10d. Inside City Limits
	B Mar	ctor	MD PRINCE	E GEORGES	SUIT	LAND	.,							XXYes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip (10g. Citizen o		
	or death with the Marylan Items 23e or 28e-f show	rai	3500 OLD SILVE			10	W D	207			Van an Na		ED ST	ATES
	hours after death with the Maryland tural', or Items 23s or 28s-f show al Erant artiflet at	Funerai	11. Marital Status 1 □ Never Married ※ Marr	12. Was Deceded Armed Force XX Yes 2	ent Everin U.S. es?	13.	If Yes, speci	ify Cubar	, Mexican	n, Puerto Ric	y Yes or No- an, etc.)		ack, White	
36	irs aft	by	3 Widowed 4 Divorced	If Yes, Give			1 ☐ Yes 🛣	X No	Specify:			Spec	ify: BL	ACK
21215-0036	i within 72 hours afte liene. r than "natural", or i		15. Deceden	t's Education	1	6a. Dece	dent's Usual	Occupa	tion	t of working	The state of the s	16b. Kind of	Business/Ir	ndustry
215	within 7 ene. than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	kind of work DO NOT use	e retired)		it of working				
7		Cou	12TH			EN'	TREPRE						VATE	
Maryland	d d d	Be	17. Father's Name (First, Middle,									Maiden Suma	am <i>e)</i>	
Z	should be ind Mental ind Mental is marked o	To	WILLIAM H. ECTO 19a. Informant's Name/Relations			10h Maili	ing Address	/Street a		RGIA I		r, City or Tow	n State 7i	in Code)
S	d 2 s thar 7 is trau	19	FLORENCE G. EC.		1		•			LL ROA		J ITLAN I		
	1 an Heal Jem 2 ther		20a. Method of Disposition	IOR / WILL	20b. Place	e of Disp	osition (Nam	e of		Date		20c. Location	•	
<u>o</u>	0 0		XX Burial 2 Cremation 4 Donation 5 Other (S		ate		matory or oti		.	4/28	/06	LAU	REL,	MD
Baltimore,	The party of	1	21. Signature of Funeral Service		, IIIIII		-	-		-	-	OF MAR		
m	Departiment of the sany or concessions	15	17. W	constll		11				ROAD		LAND,		-
e tr	Physician		23a. Part Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that can only one cause on each		Do not en	ter the mode	of dying	, such as	cardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death DAYS
	/Medical		resulting in death)	-	r as a consequen	ice of):								Dillo
	Examiner	l. I	Sequentially list conditions. b. CONGESTIVE HEART FAILURE										YEARS	
	sit s	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):										
_	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (o	r as a consequen	ice of):							-	
8760,	death certificate be executed e attending physician and of for use as the burial-transit													
687	ficate by physical ph	edical		- a.										
Box (eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy		□Ectopic pre	ananar					Date of deliv	
	death	icia	in the past 12 months? 1 □ Yes 2 □ No		nt at time of deati		Other (spe						M onth	Day Year
P.0	at the de by the stached	hys	9 🗆 Unknown								00. Bill		-4.7544-	15
	law requires that the as been signed by th 2 should be detache	by	Part II. Dther significant conditi						n in Part I	l.		obacco use co 'es 2□No		the cause of death? bably *XXUnknown
ord	v requii been s should	eted	END STAGE RENA				LLITUS),				1		
Vital Records,	e law has b je 2 sl	Completed	HYPERTENSION,	ATRIAL FIBI	RILLATIO	N					24a. Was autop		prior to co death?	opsy findings available ompletion of cause of
ä	That are page										1 Yes	XX No	1 🗆 Yes	2□ No
Vit.		o Be	25. Was case referred to medical examiner? 1 Yes XX No	Hospitals	patient 2□ER	VOutpatie	int 3□ DO	Othe		,	Check only or	<i>ne)</i> lence 6 □C	thor /Cnan	
of		<u>}-</u>	27. Manner of Death	28a. Date of (Month		b. Time		Bc. Injury Work				ow injury occ		ny)
ion	Attending I or death. ector: After by the funer	atio	XX Natural 5 Pendii 2 Accident investi	ng (Month igation	, Day Year)	Injury	М		.f /es 2□	No				
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Place L	of Injury - At home g, etc. (Specify)	e, farm, s	treet, factory	, office		28	Location (S City or Tow		mber or Rui	ral Route Number,
Ö	tal or A rs after al Dire	Cer			9, (-,,					W.				
	o the Hospital or At ithin 24 hours after o o the Funeral Direct ompletely filled in by	edical	29a. Certifier Check only 2 Medical	ng Physician: To the base Examiner: On the base and manner	sis of examination	edge, dea n and/or i	th occurred anvestigation,	at the tim in my op	e, date ar sinion, dea	nd place, and ath occurred	d due to the o at the time, o	date and place	manner as e, and due	stated. to the cause(s)
	To the	ž	29b. Signature and title of certific				29c.	. License	number			29d. Date sigi	ned (Month	, Day, Year)
,	(6)		1 K. Sint	lun				D61	614			APRIL	26, 2	006
R	-81		30. Name and address of person						011737	TODE	D.G. 0.00	1.0		
4			R.SINDHWANI 31. Date filed (Month, Day, Year,		06 IRVIN gistrar's Signatur		REET	WA	PHTNG	JIUN,	DC 200	10		
	St Regist	ate rar	APR 2 8 2		gistrar's Signatur		W							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State of Maryland / Departm	ent of Health and Mei	ntal Hygien	2006	15175	
			Decedent's Name (First, Middle, Last)		Date of Death	3.	Time of Death	
н	Physici		Margaret E. Everly	Δτ		2006 Year 2:	00 P ^M	
	/Medic Examin			City, Town, or Location of Death		c. County of Death	00 1	
		iei	Glade Valley Nursing & Rehab. Center Wa	lkersville	Date of Birth	rederick 9. Birthplace	(State or Foreign	
н	Funeral Director		217-30-5544 1 M X F 70 Yrs. Mon		(Month, Day, Year Stober 1.	r) Country)	vland	
			Usual Residence of Decedent		,		7=	
	ylan		10a. State 10b. County 10c. City, Town or Location				nside City Limits	
	Ma-1-8	Director	Maryland Washington Hagerst	own			I∏Yes 2⊠No	
	h the	ire	10e. Street and Number 10e	. Zip Code	10g. C	itizen of What Country?		
	th will		19801 Scott Hill Drive	21742	U	I.S.A.		
	lteme :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D Armed Forces? 13. Was D	ecedent of Hispanic Origin? (Specifispecify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American II Black, White, etc.	ndian,	
036	urs af	<u>م</u>	1 Never Married 2 Married 1 TVas 2 M No	es 2X No Specify:	, ,	Specify: White		
Ò	n 72 ho "netur	Completed		Usual Occupation of work done during most of working	16b.	Kind of Business/Industr	у	
215	hin 7	를	Elementary/Secondary (0-12) College (1-4or 5+)	OT use retired)				
21	filed withi Hygiene. other ther	Ö		cory Technicia	n B	iologicial	Company	
Þ	be filed within tal Hygiene. d other then event, the M	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		n Sumame)		
Maryland 21215-0036	Men Men	10 6	Lee Roy Whorton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	Margar		. Madi		
S	12 7 ic	1		odlands Run, Hag			•	
	Head Head		20a Method of Disposition 20b. Place of Disposition	(Name of Date		Location - City or Town,		
Ď	o to T		Burial 2 Cremation 3 Removal from State	or other place)		·		
Baltimore,		1		norial Park 05-01				
Ba	permit Departr Imports eny inji			e and Address of Facility Andre ast Antietam Stre			1 Home, II 21740	
		٠.	23a. Part 1. Enter the disease, or complication what caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or re	espiratory arrest,	Inte	proximate erval Between	
	Physician		Immediate Cause (Final disease or condition			On LA	set and Death	
7	/Medical		resulting in death) Due to (or as a consequence of):			7	CVIC2	
Н	Examiner		b b					
		Je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of):					
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.					
ó	exec en ar rial-tr	EX	resulting in death) Last Due to (or as a consequence of):				•	
8760,	cate be physicie the bu	dlcal	d					
9	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be datached for use as the burial-transit	P P						
Box	eath certific attending p for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectop	23d. Date of delivery				
	deatl	Cla	In the past 12 months? 4☐Pregnant at time of death 5☐ Othe	r (specify)		Month Day	Year	
Ö	t the de by the tached	hys	9 ☐ Unknown					
<u></u>	s the		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco	use contribute to the ca	use of death?	
ğ	quires n sign ald be	D D	D abetes		1∭X Yes 2	2 □ No 3 □ Probably	4 □Unknown	
of Vital Records,	w requir been si should	Completed by			24a. Was an	24b. Were autopsy	indings available	
Re	The lav	Ē			autopsy performed?	prior to comple death?	tion of cause of	
ā		ပိ	25. Was case referred to medical	OC Plane of Death (C	1 Yes 2 N	0 1 Yes 2	No	
₹	Physicien: this certificant	00	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26. Place of Death (C		6 ☐Other (Specify)		
ō		2	27. Manner of Death 1 [X] Natural 5 Pending (Month, Day Year) Injury		I. Describe how inj			
Division	Attending r death.	Certification:	14	Work?				
S	death death ctor: y the	llca	3 Suicide 6 Could not be 280 Blood of Injury. At home form street for	and the second second	Location (Street a	and Number or Rural Ro	ute Number.	
Š	or A after Direction by	i i	4 Homicide determined building, etc. (Specify)	1010, 9, 01100	City or Town, Sta			
_	pital ours a eral filled		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occu	erred at the time, date and place, and	I due to the cause/	s) and manner as stated	l	
	Hos 24 hc Fun stely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investig one)					
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Med	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day,	Year)	
	F * F 8		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					
			Jaws -	D26516	Apri	1 27, 2006		
44	1-10		30. Name of a lives of person who completed cause of death (Item 23a) (Type, Print)	#00/ T 1 1 1		1 01700		
			Allen J. Gilson, MD, 1475 Taney Avenue, 31. Date filed (Month, Day, Year) 32. Registrar's Signature	#204, Frederick,	Maryland	1 21702		
	Sta Regist	ate rar	MAY 0 1 2006 Deem S. Speed	! ,				
			THE Y I LUUU KARAN AT KARAN					

Freeman Ronald Ferguson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hy

	an/	Registrar 1. Decedent's Name (First, Middle, L	_ast)					12	Date of Dea	eg No	- 6- U h	3. Time of Death
Physici ical Exami		FREEMAN RONA	,				1	Month April 28, 2	Day	Year	1450 hrs	
		4a. Facility Name (if not institution,	-		4	4b. City, Town, or Location of Death 4c. Coun						h
		Prince George's Hospita	al Center			Cheverly				Pri	ince Georg	e's
Funeral Director		220-76-5731		e (In yrs. last 44	t birthday) Yrs.	If Under 1 Year Months Days	_	Min.	Date of Bir	th(MM/DI		rthplace (State or gn WASHINGTON puntry) DC
v any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location	n						10d Inside City Limits
Maryland 28a-f show 1 at once.	ō	MD ANNE AR	UNDEL	SEVE	RN							1 X Yes 2 No
Mary -28a- ed at	Director	10e. Street and Number				10f. Zip Code	n of What Cou	intry?				
th the 23a or		7923 BEACH PLUM				2114					U.S.A.	
Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shr or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married	ied 12. Was Decedent Armed Forces? 1 Yes 2			Decedent of His s, specify Cuban				- 1	 Race - Amer White, etc. 	rican Indian, Black.
after al", o	by F		ced If Yes, Give Year or Dates:		1	Yes 2 X No	specify:			S	pecify: B	LACK
hours natur Exam		15. Decedent's Education (Specify				s Usual Occupati st of working life.				16b. Kır	nd of Business	/Industry
thin 72 re. than " edical I	Completed	Elementary/Secondary (0-12) ${\bf 11th}$	College (1-4 or 5	5+)		EMPLOYED					PRIVAT	r.
Hygiene. Jother than the Medical	Com	17. Father's Name (First, Middle, La	ast)		DULL			Name (Fi	rst, Middle, N			<u> </u>
I and 2 should be filed with Health and Mental Hygiene item 27 is marked other the r traumatic event, the Mee	Be (FRED FERGUSON					RUTH		RRELL			
nd 2 should balth and Men m 27 is mar aumatic eve	으	19a. Informant's Name/Relationship				Address (Stree						e, Zip Code)
l and 2 sho Health and item 27 is traumati		TYNEETA M. YOUNG	/WIFE			EACH PLU		NE SE	VERN,	MARY	LAND	21144
l and f Heal f iten er tra		20a. Method of Disposition 1 X Burial 2 Cremation	3 Pernoval from Str		ace of Dispositematory or other	ion (Name of cen er place)	netery,	D	ate	20c. Lo	cation - City or	r Town, State
permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spec		uto		EMETERY	l ₁	MAY 6	2006	LANI	DOVER_M	IARYLAND
permit Department Importa		21. Signature of Funeral Service Lie				ame and Address						AL HOME
9 Q II.		X-Byerha	le			74 LANDO		ROAD	LANDO	VER,	MARYLA	
hysician Medical		23a. Part I. Enter the disease, or co failure. List only one cause on		the death. D	o not enter the	e mode of dying,	such as ca	rdiac or re	spiratory arr	est, shoci	k, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease	a Narcotic int		ion							Death
		or condition resulting in death) Due to (or as a consequence of): b.										
Sequentiarly list conditions,												
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			For State Registrar	State of	Marylar				lealth ar Death	nd Me	ental Hy	giene Reg. No.	200	5	1517
4	Physici	an	Decedent's Name (First, Middle, La	-	1 0				Journ		2. Date of D	eath Day	Yea		3. Time of Death
***	/Medi Examir		Wallace He 4a. Facility Name (If not institution, give \$INAL HOSPITAL		y, Town, o	Location of I	Death	AFRIL	27 2006 11/02 F 4c. County of Death			11,02 I M			
	Funeral Director		5. Social Security Number 6. S 212-30-9488 Usual Residence of Decedent	Sex 7. Age (In yrs. last birthday) If Under The Year Tourish Months				er 1 Year S Days	If Under 24 Hours	Min.	8. Date of Bi	te of Birth onth, Day, Year)		Count	ace (State or Foreign ry) Land
	ie Maryland 8a-f show	ctor	10a. State 10b. County Maryland Baltim										10d. Inside City Limit: 1 ☐ Yes 2 ☐ No		
	3a or 26	I Director	10e. Street and Number 9937 Old Court	Road			10f. 2	10f. Zip Code 21163				10g. Citiza			_{ry?} ites
-0036	Maryland 21215-U036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E	Armed Force 1 Yes 2 If Yes, Give Year or Date	1 ☐ Yes 2√√No If Yes, Give 1 Year or Dates:			Mas Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, e							n Indian, tc. hite
21215		Completed	(Specify only highest grades) Elementary/Secondary (0-12) 12		or 5+)	(Give	kind of v DO NOT	nt's Usual Occupation and of work done during most of working NOT use retired)					nd of Busine		ne Co.
ryland		To Be (17. Father's Name (First, Middle, Last, George Wallact 19a. Informant's Name/Relationship (ce Ford		105 14 5	-	(8:	Leah	ı_Ε.	(First, Middle Marr			•	
	jes 1 and of Health if Item 27 or other to		Dorothy Ford 20a. Method of Disposition 1 Bycial 2 XCremation 3	Wife Removal from St	20b. Place of Disposition (Name of cemetery, crematory or other place)						Wood	stock	MD cation - City	2 or Tow	1163 m, State
Baltimore,	permit. Pag Department Important: any Injury o		4 Donation 5 Other (Specifical Signature of Funeral Service Licer		SO	22	2. Name Burr	and Addres	s of Facility	une	ral Ho	me &	Crema	tor	
	Physician /Medical		Part . Enter the disease, or come shork, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	Mine.	th. Do not ent	ter the m	ode of dyin	g, such as ca	ırdiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
8760,	Examiner physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (ur	as a consec	awnes of)									
O. Box 6	The law requires that the death certific Ite has been signed by the attending pl page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ipic pregnancy er (specify)				23d. Date of delivery Month Day Year							
rds, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions of HYPERTEN SION	contributing to deat	h but not res	sulting in the u	nderlying	cause give	en in Part I.	_		tobacco us Yes 2			cause of death?
al Kecords,		Completed								_	24a. Was auto perfe 1 🗆 Yes	psy ormed?	24b. Were prior to death	o com ?	sy findings available pletion of cause of
Vital	ysiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:	atient 2] ER/Outpatier	nt 3 🗆 I	Othe			Check only		□Other (S	naciful	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury				28c. Injury at Work?		28	3d. Describe			D O CITY)	
Š	pital or Att urs after de eral Direct	Certification:	3 Suicide 6 Could not b		ry, office			City or To	wn, State)			Route Number,			
	n 24 hc n 24 hc ne Fun-	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the be niner: On the basi and manner	s of examina	ation and/or in	vestigatio	on, in my or	pinion, death	occurred	d at the time,	date and	place, and d	as star lue to t	he cause(s)
	Maithin To the comp	Ä	29b. Signature and title of certifier Pater W. C	lo			2	29c. License number				29d. Date signed (Month, Day, Year) APRIL 27, 2006			
	10		30. Name and address of person who PETER W. C'tto	completed cause of 2435 WEST	BEVE	DERE A		BALT	MORZ,	MAG	ZYLAND	77			
1	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signi	ature &	la.	<i>y.</i> .							

DHMH 17 Rev 1/2001

WALLACE

		1 - For State Registrar	State of Man	yland / Depa		Health and	Mental Hyg	•	6 1517		
Physic /Med		1. Decedent's Name (First, Middle, Lasi Jenny Helene Fo	olstad				2. Date of Deat Month Apr.	^{Day} 2006	3. Time of Death 12:45p M		
Exam	iner	4a. Facility Name (If not institution, give Household of Ar				or Location of Deat		4c. County of Deal			
Funera Directo		5. Social Security Number 6. Se	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days		8. Date of Birth	Year) 9. Birt	e Arundel hplace (State or Foreign horway Norway		
deeth with the Maryland rms 23e or 28a-f ehow rmst be notified at	Director	10a. State 10b. County MD Anne A	0c. City, Town or Lo	everna P	ark			10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
With t		10e. Street and Number 22 Windward Driv	<i>7</i> 0		10f. Zip Code	1146	1	og. Citizen of What Co			
"netural", or ite	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit			
	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)	ucation de completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wo	rking		b. Kind of Business/Industry		
filed w Hygier other th		12 17. Father's Name (First, Middle, Last)			Homema.		me (First, Middle, A	Home			
should be filed within nd Mental Hygiene. merked other then imatic event, the Ma	To Be	Arnt Aarum					Tenglesei				
2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	ig Address (Street			City or Town, State, 2	Zip Code)		
1 end 2 Health a om 27 is		Kristine Johnson/	'Daughter	22	Windwar	d Drive,	Severna 1	Park, MD	21146		
permit. Peges 1 end 2 should Depertment of Heath and Mer Importent: If Item 27 is marke any Injury or other traumatic ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	Metro Cr	ematory or other pla		2006	20c. Location - City or Baltimore,	MID		
Depertition of the concession		21. Signature of Edneral Septice Licens	Town!	Bai 49	Name and Addre	Sons, P.	A. Severi	na Park Fu na Park, M	neral Home D 21146		
Physician /Medical Examines and pural-transit principle		236 Part1. Enter the disease, or come shock, or heart failure. List only come shock or heart failure. List only come disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	ngestive I					Approximate Interval Between Onset and Death 2 yrs.		
To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours effer death. To the Funerel Director: After this certificate hes been signed by the ettending physicie completely filled in by the funeral director, page 2 should be detached for use es the bur	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		23d. Date of del Month	ivery Day Year						
quires that in signed b uld be deta	र्व	Part II. Other significant conditions co	ntributing to death but r	not resulting in the ur	nderlying cause gr	ven in Part I.		acco use contribute to	the cause of death?		
The law receive her been page 2 sho	Completed						24a. Was ar autops perform	y prior to d	itopsy findings available completion of cause of 2 No		
ilcien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		0"		ath (Check only one	·	Assisted		
ath. r: After this	ation: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yo	28b. Time of	28c. Inju	DOA Cther: 4 □ Nursing Home 5 □ Residence 6 ② Other (Specify) 28c. Injury at Work? 1 □ Yes 2 □ No					
Ital or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	eet, factory, office	-	28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,		
he Hoep in 24 hou he Funei pietely fil	edicai	29a. Certifier 1	rsician: To the best of n iner: On the basis of ex and manner stated	camination and/or inv	occurred at the ti restigation, in my o	me, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)		
To t To t com	W	29b. Signature and title of certifier.	Berez	MP	29c. Licens	se number 295	_	9d. Date signed (Mont) $4/24/26$			
		30. Name and address of person who c Paul B. Berez, M.		th (Item 23a) (Type, I Defense Hi		e E, Crof	ton, MD	21114			
St Regis	tate trar	31. Date filed (Month, Day, Year) APR 2 6 20	32 Aegistrar's	Signature	will !						

the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be

To the Hospitel or Attending Physician:

death.

after

this

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Year Winfield April 22, Crawford Frank 3:31 p. M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year Sept. 18, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director Yrs. 527-36-5538 74 1931 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in than "natural", or Itams 23s or 28s-f show The Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Queen Annes Grasonville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 320 Narrows Pointe Drive 21638 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or item other traumatic event, it a Michigal Examine. Black, White, etc. t Fixes 2 □ No 1956 – If Yes, Give Year or Dates: 1979 1 Never Married XX Married 1 ☐ Yes 2√∑ No Specify ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Officer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John C. Zook Florence Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara F. Frank (wife) 320 Narrows Pointe Dr. Grasonville, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Arlington National Cemetery June 28, 2006 Arlington, Virginia 22. Name and Address of Facility Advent Funeral & Cremation Services M00982 7211 Lee Highway Falls Church, Virginia 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NOXIC Friysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 🗌 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 📆 No 1 Papatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation M Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29d. Date signed (Month. Day, Year) 32/2006 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Kesnich

State Registrar 31. Date filed (Month, Day, Year) APR 26 2006



		For State Ragistrar	State of Marylan	d / Depa <i>Cer</i>	artment of H	lealth and N Death	Rag	ene 200 (15180		
Physici		1. Decedent's Name (First, Middle, Last)	ernandes				2. Date of Death April 24	Day 2006 Yeer	3. Time of Death 9:30A M		
/Medic Examin		4a. Fecility Name (If not institution, give si Suburban Hospital			4b. City, Town, or Betheso	Location of Death		ry			
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 67	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth July 26	9. Birt 1938 Po	nplace (State or Foreign		
nyland bhow d at	_	Usuel Residence of Decedent 10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits fX☐ Yes 2☐ No		
n with the Me 3a or 28a-f	al Director	Maryland Montgomes 10e. Street and Number 4977 Battery Lan	"-5	Bethes	10f. Zip Code 208	14		10g. Citizen of What Country? Inited States of Americ			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show any Injury or other traumatic avent, Ite Natural Examinational termitlised at once.	by Funeral	11. Marital Status 1 Never Married	2. Was Decedent Ever in U Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S) an, Mexican, Puerto Specity:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify:			
	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	(Giv life.		dent's Usual Occup kind of work done DO NOT use retired aterer	during most of wor.		16b. Kind of Business/Industry Food Service			
of 2 should be filed within 72 hours after and Mental Hygiene. 77 is marked other than "naturel", or traumatic avent, the Martical Exami	To Be Co	17. Father's Name (First, Middle, Last) Alfredo Fernandes					ne (First, Middle, M na De Sa	aiden Sumame) ntos Ferna	indes		
end 2 shou saith and M n 27 ie mar ar traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z Olivia Lorenzato Fernandes - Wife 4977 Battery Lane #316, Bethesda, MD									
rmit. Pages 1 er partment of Hea portent: If Item 3 y Injury or other ICE.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State Ft.	emetery, crer Linco	oln Crema	tory 04/	/28/06	Oc. Location - City or Brentwood,	Maryland		
Depar Impor any In		21. Signature of Eugerat Sérvice License	~`		1800 New	Hampshir	ce Ave. S	ilver Spri	1 Home, Inc. ng, MD 2090		
Physician /Medical Examiner		23a. Park Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Sersis Due to (or as a consect Cellulitis		er the mode of dyir	g, such as cardiac	or respiratory arres	51,	Approximate Interval Between Onset and Death Day 3 Days		
icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, fram, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec								
death certif e attending id for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Gc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	□Ectopic pregnance □ Other (specify) _	,		23d. Date of de Month	ive ry Day Year		
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e law has t	Completed	Renal Failure, Re	nal Transpla	nt			24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of		
Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital: Y		-t 20 004 Ott	100	ath Check only one				
ing Phy After this uneral d	ation: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	ospital: 1 Inpatient 2 C 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur	4 LI NUISING F	28d. Describe ho	nce 6 ⊡Other (Spe w injury occurred	cify)		
교 # 등 드	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At a building, etc. (Special	eet and Number or R , State)	ural Route Number,						
e Hospital 24 hours a te Funerel i	Medical		sician: To the best of my kn ner: On the basis of examin and manner stated.								
To the To the complete	Me	29b. Signature and title of certifier	- MD		29c. Licens	se number 0060117		od. Date signed (Moni	igned (<i>Month, Day, Year</i>) 26, 2006		
1"		30. Name and address of person who co Eric Park, MD		m 23a) (Type Center	Drive, F	Rockville	, MD 2085	60			
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 8 20	32 Registrar's Sign	ature	will						

Fernandes, Marcelino

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 515 M **Physician** ALMA GREENE 16 APRIL 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL RANDAUS COWA NERTHWEST Covitin BACTINEERE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 9 72 7 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ ¥ Washington, 61 Director 579-56-5234 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. r then "naturel", or Itema 23a or 28e-f eho the Medical Examinar must be notified at MD Y☐Yes 2☐No **Funeral Director** Baltimore Randallstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Towhee Court 21133 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Deceden! Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher's aide Daycare traumatic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 1 end 2 should be William Reynolds Margaret Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a litem 27 in other tra Margaret Tate - Daughter 1 Towhee Court; Randallstown, Maryland 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 nent of H ant: if ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Depertment of Important: if eny injury or once. Harmony Memorial Park 05/04/2006 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Freeman Funeral Services 5801 Cleveland Avenue; Riverdale, MD 23a. Part1. Feer the disease, or commutations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulling in death) OBSTRUCTIVE REMIENARY DISTRISE **Physician** CHRENEC END STAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? MElliters 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of dealh?

1 Yes 2 Die 24a. Was an IVEDGE RESERTOR 2 10 No 1 Yes of Vital after death.

Director: After this certification in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Lapatieni Other: 4 Nursing Home 5 Residence 6 Olher (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date ol Injury (Month, Day Year) 28c. Injury al Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 TYes 2 TNo 2 🗀 Accident 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide pelli within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

31. Date liled (Month, Day, Year)

MAY 0 1 2006



my

30. Name and address of person who completed cause of feath (Item 23a) (Type, Print)

K)

RANDALISTENN, MARYLAND 211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Warren Gantt 2:10 P M Apr 25, 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Solomons Solomons Nursing Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X**]M 2□F Yrs 84 Mar 13, 1922 Maryland 213-22-2384 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County other then "naturel", or Items 23e or 28e-f ehow vent, the Medical Executer roust be notified at 1 ☐ Yes 2 XNo Port Republic Director MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20676 3495 Hance Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black δ 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Laborer 6 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other treumatic event page. 17. Father's Name (First, Middle, Last) Charlotte Golder Warren Gantt, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3495 Hance Road Port Republic, MD 20676 Archie Gantt/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/02/06 St. Leonard, MD **Brooks UM Church Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit 21. Signature of Funeral Service Licensee Sewell Funeral Home Glader a 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arrhy thmic ardiac **Physician** disease or condition resulting in death) /Medical Atheroscierotic Cardiovascular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by mellitus - Insulin Dependent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Dementia this certificate 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending within 24 hours after death.
To the Functal Director: Alt

1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-50653 4-26-2006 1EU -ana.

State

Medical

5851-Deale Church ton 31. Date filed (Month, Day, Year) 32. Registra Signature 6

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN - C. SURANA Rd. Deale miles

	1	For State Registrar		laryland / [Certifica				Reg. No	006	15183
sicia	n	Decedent's Name (First, Middle, La William Gle	,	~				2. Date of De	Day	Year	3. Time of Death
ledica		4a. Facility Name (If not institution, gir			4b. Cit	/. Town, or	Location of Dea	April	21 4c. Co	2006 unty of Death	5:25 a. ^M
amine		Ridgeway Manor		•			nsville			Baltim	
eral				ge (In yrs. last birt	hday) If Und Month	er 1 Year Days	If Under 24 Hr Hours Mir			9. Birth	place (State or Foreign
tor		217-10-0743	1 25 M 2□F	91	Yrs.	Jayo	770010		6, 191		yland
1	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
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ery injury or other traumatic event, the Malical Examinar must be nothing an once.	Funeral Director	10e. Street and Number			10f. 2	ip Code			10g. Citizer	of What Cou	intry?
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Der	nue	 Marital Status Never Mamed 2 Married 	12. Was Deceden Armed Forces 1 XYes 2	?	13. Was Dec	edent of Hi ecify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or Norto Rican, etc.))- 14.	Race - Ameri Black, White,	
EBX	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 ☐ Yes	2 3 No	Specity:		Sp	ecify: W.	hite
ICBI I	ted	15. Decedent's E (Specify only highest gr	ducation	16a.	Decedent's Us	ual Occupa	ation	odvina	16b. Kind	of Business/Ir	ndustry
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		17 Esther's Name /First Middle 20)\		tr	ack d	river	/Fi 1 6 d d l		nsport	ation
	Be	17. Father's Name (First, Middle, Las. Glenn S. Gill						ame (First, Middle			
	ှ	19a. Informant's Name/Relationship		19h	Mailing Addre	ss (Street a		Elizabetl Rural Route Numb			p Code)
		Charlotte Aldri						ırt, Elki			1075
		20a. Method of Disposition		20b. Place of	Disposition (Ny, crematory or	ame of		Date		ion - City or T	
		1 Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci		Marylar			· 1	/24/06	Hurl	ock, M	D
ouce.		21. Signature of Funeral Service Lice	nsee				s of Facility	Thomas I	unera		
Я		the I	em					Cambridge		21613	
in al		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	_{a.} sepsis	from inf	ected:						Approximate Interval Between Onset and Death 6 days
er				le infarc		ntia					8 years
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	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 □ Fetal death at time of death	3 □Ectopic 5 □ Other (23d	. Date of delive Month	ery Day Year
- 1	<u> </u>	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying	cause give	on in Part I.	23e. Did	obacco use	contribute to t	the cause of death?
	ا ٔ ه	chronic renal			,			1 🗆	Yes 208/N	lo 3 Prot	bably 4 [Unknown
	ete							24a. Was	an 2	4b Were auto	opsy findings available
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	0	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath (Check only	2 S No	1 🗆 Yes	2□ No
	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🗆 Inpat	ient 2 ER/Ou	patient 3 🗆 [Othe Othe		Home 5 ☐ Resi		Other (Specia	fy)
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	catl	2 Accident investigation 3 Suicide 6 Could not to	10		М	101	res 2□No				-
	Certification:	4 Homicide determined	28e. Place of I	njury - At home, fal atc. <i>(Specify)</i>	rm, street, facto	ry, office		28f. Location (City or To	Street and N wn, State)	umber or Rura	al Route Number,
	edical	29a. Certifier (Check only one) Certifying P	hysicien: To the bes miner: On the basis and menner s	of examination and	, death occurre Vor investigation	d at the tim	e, date and plac sinion, death occ	e, and due to the curred at the time,	cause(s) and date and pla	d manner as s ice, and due to	stated. o the cause(s)
	Σ	29b. Signature and title of certifier	2//	1	2	9c. License		C		gned (Month,	
		Jehn ?	mun	on P		D	1955	5	04	-26-	2006
		30. Name and address of person who Glen E. Johnson,									
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		1	For State Ragistrar	State of Maryland	d / Depa <i>Cer</i>	rtment of H	ealth and M Death		ene20	06	15184
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	/Medic Examin		Ha. Facility Name (If not institution, give Renaissance Gardens a		ge	4b. City, Town, or Silver	Location of Death Spring		4c. County		omery
	Funeral Director		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 2,	Year) 1919	9. Birthp Cour	place (State or Foreign ntry) Maryland
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	with the M a or 28a-f be notifie	ਙ	10e. Street and Number 9501 Seminole St			10f. Zip Code 20901		10	g. Citizen of \	What Cour	ntry?
36	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "neturel", or Items 23s or 28s-f show event, the Medical Exatrical must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII	ľ	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blad	ce - Americ ck, White, fy: Whit	
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	es 1 and 2 should be for the solution of Health and Mental if item 27 is marked of the contraction of the treumatic eversity.		19a. Informant's Name/Relationship (Stephen Craig Gil 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	lis/ Son 20b. F	9501 Place of Dispo	Seminole sition (Name of natory or other place	Street,	Silver S	Spring,	MD 2	20901 Jown, State
Baltimore,	permit. Pages because the Department of Humbortant: If ite any injury or ot once.		*4 Donation 5 Other (Specification of Funeral Service Licer) Par	22 F r	emorial Par Rame and Addre	ss of Facility Collins	Funeral	Home I	nc	Maryland , MD 20901
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Ω.	requires that t een signed by nould be detac	ed by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the u	inderlying cause giv	ven in Part I.				the cause of death?
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Division of Vital Records,	fter fter	H-1	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju Wo	ry at	28d. Describe ho	ow injury occu	ırred	
Divis	i Diffig	Certification;	3 Suicide 6 Could not to determined	building, etc. (Speci	ify)			City or Town	n, State)		ral Route Number,
	e Hospital 24 hours e e Funeral l	Medical	29a. Certifier (Check only one) Certifying P Certifying P 2 Medicel Exe	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or in	th occurred at the ti	ime, date and place opinion, death occu	irred at the time, d	ate and place	and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	eint un			se number 433 75		19d. Dave sign	ed (Month	n, Day, Year)
_	75		30. Name and address of person who Karen Merritt, I	completed cause of death (Ite 1.D. 3110 Gra	m 23a) (Type acefie:	Print) Ld Road,	Silver S	pring, M	20904	1	
	Si Regis	ate trar	31. Date filed (Month, Day, Year) MAY 0 1	32 Registrar's Sign	d A	ali					

			For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H			giene Rag. No 006	15185
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	/Medic Examin		4a. Facility Name (If not institution, Carroll Hosp	give street and numbe		4b. City, Town, or Westmi	Location of Death		4c. County of Dea	
	Funeral Director				Age (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 12-5-	h v, Year) 9. Bir	rthplace (State or Foreign ountry) Ode Island
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the Ma	r 28a-f s	Director	MD Carr 10e. Street and Number	.011	Hampst	ead 10f. Zip Code			10g. Citizen of What C	1 □ Yes 2√ No ountry?
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IIIQ 6 16 15 15 10 00 00 00 00 00 00 00 00 00 00 00 00	ital Hygiene. id other then "natural", or items 23s or 28s-1 show event, it a Madical Exteninst mast be notified at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force and 1 Yes 2[If Yes, Give Year or Date	₹ ^N °	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
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nit. Pag	artment ortant: I injury o		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Li	eĉily)	RI Vete	2. Name and Address	ss of Facility			Rhode Islan
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22		1	23a. Pal 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	omplications that cause on each	h line.	iter the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
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The faw requ	ste has bee page 2 shor	completed	RENAL FA	ILURE				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
VILCA Sician:	certifica rector, I	BeC	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dea	th (Check only or	ne)	
ing Phys	h. After this certificete has funeral director, page 2 s	lon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of I (Month,	atient 2 ☐ ER/Outpatie njury 28b. Time o Day Year) Injury	of 28c. Injury Wari	y at k?		lence 6 Other (Spe low injury occurred	icity)
or Attending	after death Director: , I in by the f	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At home, farm, st etc. (Specify)		Yes 2 □ No	28f. Location (S City or Tow	Street and Number or R rn, State)	ural Route Number,
- Hospite	within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be examiner: On the basis and manner	est of my knowledge, dea s of examination and/or in stated.	th occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the corred at the time, co	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	Withir Somp	Me	29b. Signature and title of certifier	felou,	M.A.	DOC	number 69	-	April 29	th, Day, Year) 7, 2006
ν	6		30. Name and address of person w Abdallah J.	Helou, 1	M.D., 200		l Ave.	Westmir	ster, MD	21157
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0		trar's Signature	Soule				

			1 - State of Registrar		artment of Health and rtificate of Death	Mental Hygie	2000 1	5186
			Decedent's Name (First, Middle, Last)			2. Date of Death Month		. Time of Death
	Physici /Medio Examir	cal	Richard Charles Grove 4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of Deat	April	Day Year 27 2006 4c. County of Death	12:24P M
	Funeral Director		217–16–2982 ¹X M 2□F	. Age (in yrs. last birthday, 84 Yrs.	Hagerstown If Under 1 Year - If Under 24 Hrs Months Days Hours Min.	(Month, Day, Ye	Washington 9. Birthplece Country) 921 Ohio	County (State or Foreign
	and *		Usuel Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation		10d.	Inside City Limits
	e Marylan a-f show	ctor	Maryland Washington	Hage	erstown			1 □Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?	
	ath w	rail	20027 Gilbert Hills Dri		21742		U.S.A.	
920	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show "Jical Evaculant mat be notified at	by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never M	.□ No 8-39-44	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 ☐ Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American I Black, White, etc. Specify: Whit	·
215-0036	- 100	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	rking 16t	, Kind of Business/Industr	у
212	be filed within tral Hygiene. Id other than "event, It a Me.	E O	Elementary/Secondary (0-12) College (1-	for 5+)	Machinist		Truck Manufa	cture
	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	18. Mother's Nar	me (First, Middle, Mai	den Sumame)	
/lar	should be nd Mental marked o	ToE	Paul Charles Grove		Hazel	Irene Wol	perton	
Maryland	2 sho and h is ma		19a, Informani's Name/Relationship (Type, Print)	19b. Mait	ing Address (Street and Number or Ru	ıral Route Number, Ci	ty or Town, State, Zip Coo	ie)
Baltimore, M	ges 1 and 2 should it of Health and Men If Item 27 Is marke or other traumatic		Joyce LaRue Grove (wife 20a. Method of Disposition 1 [XBurial 2] Cremation 3] Removal from S	20b. Place of Disposate	matory or other place)	Date 200	. Location - City or Town,	State
Ë	Parit and Parit		` 4 ☐Donation 5 ☐ Other (Specify)	Rest Hav	ven Cemetery May	1, 2006 F	Magerstown M	aryland
Bal	permit. Pag Department Important: any injury c		21. Signature of Funerat Service Licensee		2. Name and Address of Facility Do 331 Eastern Blvd.	-	iery Funera	
3760,	Physician and water the private and the private the private the private the private that th	ical Examiner	shock, or hear failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (conditions)	rasa consequence of): A fulling - K as a consequence of): ras a consequence of):		ylo co rec	2 Ouron	arval Between set and Death
P.O. Box 68	law requires that the death certifical as been signed by the attending phy 2 should be detached for use as the	Physician/Med	in the past 12 months?	nt at time of death 5[□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
	signed by		Part II. Other significant conditions contributing 6 dec	th but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the ca	
Records,	law requir as been si 2 should I	Completed by	Eloronary Files	, Deisan	00 Hyporter	Was an Julopsy	24b. Were autopsy f	indings available
E.	ding Physician: The lav h. After this certificate has funeral director, page 2:	Con		/	" "/	performed 1 ☐ Yes 2	? death?	No
Vital	Physician: r this certific ral director, I	Be	25. Was case referred to medicat examiner?			th (Check only one)		
of	Physi this al dir	ဥ		patient 2 ER/Outpatie		- 	6 □Other (Specify)	
L	ding After	io	1 Natural 5 Pending (Month	Injury 28b. Time of Injury Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how it	itury occurred	
Division	or Atten after deat Director; in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of	f Injury - At home, farm, st g, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Rol ate)	ute Number,
	the Hospital nin 24 hours a the Funeral upletely filled	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the base and manner.	is of examination and/or in	th occurred at the time, date and place execution, in my opinion, death occurrences.	, and due to the cause rred at the time, date	e(s) and manner as stated and place, and due to the	cause(s)
1	To the within To the	Me	29b. Signature and title of certifier	2	29c. License number	29d.	Date signed (Month. Day,	Year)
,				of death (feet 22 to 27	201010		1-100	
4	H 5+1		30. Name and address of person who completed cause	or death (Item 23a) (Type,	1 310 mie	0 St. H	ogerston	MO
	Sta Regist	_	31. Date filed (Month, Day, Year) 32. B	gistrar's Signature	ask)			21790

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Hoover Vernon May 10, 2006 Ray 1:00 pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Box 25909 Oldtown Road SE Oldtown Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Y. May 22, 9. Birthplace (State or Foreign **Funeral** . 1<u>910</u> 1 M 2 □ F WW 236-50-2237 95 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany MD Oldtown Be Completed by Funeral Director 1 Yes 2 No 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? Box 25909 Oldtown Road SE 21555 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 1942-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) foreman Consolidated Orchard permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If tem 27 is marked other tt eny injury or other traumatic event, IIIA QDCB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tilman H. Hoover Sally J. Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 25705 Oldtown Rd Dawn McDonald friend Oldtown MD 21555 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 5/11/2006 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Nam}Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Medical Certification: To Be Completed by Physician/Medical Examiner Due to for as a nonsequence of that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 No 1 ☐ Yes 2 ₽No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

/Medical Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, attending physical for use as the t cate has been signed by the a page 2 should be detached to Division of Vital Records, this certificate : After this certifical e funeral director, p death.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

worle

in then "naturel", or items 23a or 28a-f eho the Medical Exantrar must be notified at

Hygiene.

within 24 hours after death To the Funeral Director: completely filled in by the

Registrar DHMH 17 Rev 1/2001

Beverly Calkins M.D. th, Day, Year) MAY 1 5 2006

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Sgatrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D54411

500 Memorial Ave Ste 105 Cumberland MD 21502

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Elizabeth Wilhite Holman

	1 F	For State Registrar Amend#8 PerFH PCC5-10-06 cr Cert	tificate of Death		Reg No. 0006 1510
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of De Month	Day Year
Medical Examin		ELIZABETH WILHITE HOLMAN	4b. City, Town, or Loc	April 24,	4c. County of Death
		 4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center 	Cheverly	ation of Death	Prince George's
Funeral		5. Social Security Number 6 Sex 7. Age (In yrs. la	,		Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		251-32-4698 1 M 2XF 81	Yrs. Months Days	Hours Min. March	
*		Usual Residence of Decedent	T and analism		10d. Inside City Limits
w any			Town or Location		1 X Yes 2 No
Maryland 28a-f show datonce.	ġ.		rict Heights		10g. Citizen of What Country?
Mary r 28a ed at	Director	10e. Street and Number			
with the Maryland ns 23a or 28a-f sho be notified at once.		6415 Elmhurst Street 11 Marital Status 12 Was Decedent Ever in U.S	20747 3. 13. Was Decedent of Hispar	nio Origina / Specify Vos or N	U.S.A. No- 14. Race - American Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces?		exican, Puerto Rican, etc.)	White, etc.
ter de		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	1 Yes 2 X No s	pecify:	Specify White
urs af	함	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
5 72 ho n "na	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DC	·	
21215-0036 John 2 hours after Mental Hygiene. marked other than "matural", o	Completed	12	Administrative		Federal Government
filed v Hygi d oth		17 Father's Name (First, Middle, Last)		Mother's Name (First, Middle	e, Maiden Surname)
2121 uld be fil Mental E marked c event,	e Be	Thomas Wilhite 19a. Informant's Name/Relationship (Type, Print)		Vivian Byrd nd Number or Rural Route No	umber, City or Town, State, Zip Code)
MD 2 d 2 shou lth and N n 27 is n	F	Carole Schulman - Niece	A1		
= □ = = =	-	20a Method of Disposition 20b. P		ery, Date	, Maryland 20854 20c. Location - City or Town, State
5 ∞ 5 5 5 1		A Dultai Z Cremation 3 Nemovaritomptate	rematory or other place) ar Hill Cemetery	5/3/2006	Suitland, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If iter	ł	4 Donation 5 Other Specify Ced. 21. Si nature / Funeral Septice Live	22. Name and Address of	Facility Gasch's F	uneral Home, P.A.
Dep De Injin	-	Latest (Ilay	4739 Baltimo	ore Ave., Hya	ttsville, MD 20781
Physician		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, suc	ch as cardiac or respiratory a	arrest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Atherosclerotic Cardiova			Death
	- 1	or condition resulting in death) Due to (or a consequence of):		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	·).		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of			
ited d ansit		events resulting in death) Last Due to (or as a consequence of d.	<i>y</i> -		
Division of Vital Records, P.O. Box 68760, To the Hopital or Artending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	/Medical	UNPENDED AMENDED			
760, ficate be g physici the buri	§ S	IF FEMALE: 23c. If yes, outcome of pregr	nancy		23d. Date of delivery
Ox 687 cath certificattending	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth The pregnant at time of december 2.5 bigs of the past 12 months?	2 Fetal death 3 ath 5 Other (Specify)	Ectopic pregnancy	Month Day Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		1
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P.C.	d by	Diabetes Mellitus		1 Y	res 2 ✓ No 3 Probably 4 Unknown
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eco he law te has	duc				rformed? death? s 2 No 1 7 Yes 2 No
ital Recicion: The secrificate rector, page	Be C	25. Was case referred to medical		Death (Check only one)	
Vita ysicia ysicia this co	0	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient 3 DOA Ott	her Nursing Home 5	Residence 6 Other:
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safer death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	L L	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury a		e how injury occurred
ion ftend death ctor: y the f	atic	2 Accident Investigation		3 2 No	
IVIS I or A after Dire	Certification:	3 Suicide Could not be	ome, farm, street, factory, office build	ding, etc. 28f. Location or Town	n (Street and Number or Rural Route Number, City n, State)
ospita hours uneral		4 Homicide 29a Certifier Provide The back of multipopular	ms death aggurrad at the time date	and place, and due to the co	aurea(s) and manner as started
Division of Vi To the Hospital or Attending Physi within 24 hours after death To the Funeral Director: After this completely filled in by the funeral di	Medical	one) Medical Examiner: On the basis of examination a			
To To con	Mec	and manner stated. 29b Signature and title of dertifier	29c. License r	number	29d. Date signed (Month, Day, Year)
		1 Jakoko III	O.C.M.	E.	April 25, 2006
		Name and address of person who completed cause of death (Item		<u>-</u>	<u> </u>
JR (10)		Laron Locke MD. Assistant Medical Examiner	111 Penn Street, Baltimo	ore, MD 21201	
	ate	31. Date filed (Month, Day, Year) MAY 0 2 2005 Registrar's Signer	ire foods		
Regist	ur.li	WHI A CONO	-/		

State of Maryland / Department of Health and Mental Hygiene

				Otate of Maryle	•	tificate o		•	Reg. No.	06	15189
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4	/Medi		Odessa Louise				T., 60 =	Apri	1 15,0	2006	2.00 AM
	Exami	ner	4a Fecility Neme (If not institution, give Doctor's Hospita				4b. City, Town, or Lanham		PG		
	Funeral Director		5. Social Security Number 6. Se 579–34–8247	7. Age (In yi	rs. lest birthday) Yrs.	Months Day			th ey, Yea <i>r)</i> 1928	9. Birthplace Country) N. Car	e (State or Foreign) rolina
	dand		10a. Stete 10b. County	10c.	City, Town or Loc	ation				10d.	Inside City Limits
	Mary Mary	jo	MD PG		Cheverly						Ng Yes 2□ No
	or 28	je e	10e. Street end Number			10f. Zip Code	Э		10g. Citizen of	What Country?	?
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Maryland 21215-0020	s 1 and 2 should be filed within 72 hours efter deeth with the Maryland of Heelth end Mentel Hygiene. I them 27 is marked other than "naturel", or flems 23e or 28e-1 show other treumstic event, the Medical Examiner must be notified at	l by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates:		/as Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)		ce - American I ck, White, etc. y: Black	
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d 2	Hygie Hygie ther		17. Father's Name (First, Middle, Last)		пос	rsewite		me (First, Middle		mestic me)	
/an	should be filed withir and Mentel Hygiene. merked other than umatic event, the Mentel	To Be	John Thurman Peri	сy			Katie	e Perry			
lary	2 should help me!	-	19a. Informant's Name/Relationship (T		19b. Mailing	Address (Stre	eet and Number or R	u <i>rel Route Numb</i>	er, City or Town,	Stete, Zip Co	ide)
	and leelth m 27 in		Brenda L. Hall - I				er Road #				
Baltimore,	Demit. Peges 1 a Deportment of He mportant: if item any Injury or other page.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ I	removal from State	. Place of Dispos cemetery, crem			Date	20c. Location -		
Itim	permit. Peges Depertment of I Important: if ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funetal Service Licens		Resurrect		denne of Facility	04/24/06			
Ba	Depe Impo		Our Distriction of Pulls and Service Electric	ntreena	Dones		riess of Facility Fi veland Ave	reeman F enue; Ri			es 20737
			23a. Part1. Enter the diseese, or composhock, or hear failure. List only of	lications that caused the de	eth. Do not ente	r the mode of o	tying, such as cardia	c or respiratory a	rrest,	Inte	proximate terval Between
-	Physician /Medical Examiner		Immediate Cause (Final disease or condition	Lower Gast						On	nset and Death
	LAUIIIIIei	<u>_</u>	resulting in death)		(or as e consequ	uence of):					
	s rusit	min		Bacteremia							
oʻ	axacı an and rial-tra	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Critical A	ores a consequence or startic St						
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<u>₹</u>	Physician: The rath contificate are director, pag	å	25. Was case referred to medical examiner?	Hospital:			Whar:	ath (Check only o			
	Phys	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	☐ ER/Outpatient 28b. Time of	3 DOA 28c. In	4 LI Nursing r	lome 5 Resident	dence 6 ⊡Oth how injury occur		
on	Attending Phy or death. ector: After thii by the funeral	ફ	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day Year)	Injury		vonk? □Yes 2□No				
Division	al or Attendi s after death i Director: A id in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe		et, factory, offic	Ce C	28f. Location (: City or Tox	Street and Numb wn, State)	er or Rural Ro	oute <i>Number</i> ,
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: complataly filled in by the	edicai C	29a. Certifier (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inve	occurred at the estigation, in m	time, date end place y opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as stated and due to the	d. e cause(s)
	Vithir Comp	M	29b. Signature end title of certifier	10		29c. Lice	ense number		29d. Date signe	d (Month, Day	, Year)
			I. Cre	ends	MD	D	0062116		04/24	1/2006	
n /	115)	30. Neme and address of person who co								
			Meklit Workneh, 31. Dete filed (Month, Day, Year)	M.D. 7705 2. Registrer's Sig	Belle Po	int Dri	ive, Gree	nbelt, M	Maryland	20770)
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:52P M APRIL 26 2006 HART CHARLIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1√2 M 2□ F Director 577-72-7762 50 9 1955 WASHINGTON.DC Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits d other than "naturel", or Items 23s or 28s-f ehow event, the Modical Examiner must be notified at 1 Yes 2 No Directo PRINCE GEORGE'S UPPER MARLBORO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20774 U.S.A. 73 HERRINGTON DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mentat Hygiene. Inportent: If item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Examinat. 2000. 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2√ No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) PRIVATE LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLIE HART LULA BELL STIGGINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 73 HERRINGTON DRIVE UPPER MARLBORO, MARYLAND 20774 MARY WILLIAMS/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 5/3/2006 CLINTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** henman /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physicien Physician/Medical as the t attending IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy ₽ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 99 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an After this certificate has 1 Yes To the Hospital or Attending Physician; funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tmpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 ZiNatural 5 Pending 1 Tes 2 No death. investigation 2 ☐ Accident filled in by the Director; 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

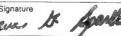
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. PATRICK DRIVE WALDORF, MARYLAND 20603 10 NALIN_MATHUR M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 0 1 2006

ORIGINAL

		Plea	se Type or							•		•		
		1 - For State Registrar	State o	i Maryl	and / De <i>C</i>	partme <i>ertifica</i>				ental Hy	/giene Reg. No	2000	15	9
Physic	ion	1. Decedent's Name (First, Midd								2. Date of Do			3. Time o	f Death
Physic /Medi	cal	MARY 4a. Facility Name (If not institution	FRANCES		HAVENNE		Tour or	- Logotion	of Death		29,	2006 County of Dea	11:10) P ^M
Exami	ner	WALDORF HEALTHO	ARE CENTE	R	4b. City, Town, or Location of Death WALDORF wrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date						CHARLES			
Funeral Director		5. Social Security Number 577-84-5807	6. Sex 1 □ M 2 💢 F	-	yrs. last birthda 34 Yrs	Month		Hours	Min.	8. Date of Bi (Month, D	7, Year	921 Was	thplace (State puntry) hingtor	•
land ow]	Usual Residence of Decedent 10a. State 10b. County	1	10c	. City, Town or	Location							10d. Inside C	City Limits
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with the a or 26	Funeral Directo	10e. Street and Number 3315 Erik Cour	.+			10f. 2	Zip Code	0601			10g. Ci	itizen of What C	ountry?	
death ms 23	neral	11. Marital Status	12. Was Dec		in U.S. 1	3. Was Dec			igin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Am		
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!', or items 23a or 28a-1 show eny injury or other treumatic event, the Modical Examinating Incilliad at 900s.	þ	1 Never Married 2 Mai	# Voc Gi	2₫No ve			X No	Specify:		Hican, etc.)		Black, Whi	USA	
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of Hear		20a. Method of Disposition 1 □ Burial 2 □ Cremation		State	b. Place of Dis cemetery, o	sposition (A crematory of	lame of r other plac	(e)	C	ate	20c. L	ocation - City or	Town, State	
Dattillo bermit. Peges Department of mportant: If i any injury or o		4 Donation 5 Other (21. Signature of Juneral Service	Specify)		Huntt C	remat			5-1-0			dorf, MD		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 🗆 Live t	oirth 2 🗍	Fetal death	3 Ectopic 5 Other (,				23d. Date of de Month	-	Year
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133		30. Name and address of person MANISHA JARLWA	LA, MD, 11	L637 T	ERRANC	E DRIV	VE, S	UITE	103,	WALDO	RF, i	MD		
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Registrar DHMH 17 Rev 1/2001

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Physic	ian	Decedent's Nam							2. Date of I		2006	Year	3. Time of Death 7:20 A M
/Medi Examir	cal	4a. Facility Name (Ralph He		ber)		4b City Town	or Location of De	April	21	4c. County	of Death	7.20 A N
Examir	er -	2132 Das	sher Driv	<i>7</i> e			Lusby		-		Calve		
Funeral Director		5. Social Security N 066-30-26 Usual Residence of	583	Sex 1☐xM 2☐F	7. Age (In yrs. 68		If Under 1 Year Months Days			Birth Day, Yo 29	1938	Cou	
Maryland	ctor	10a. State Maryland	10b. County Calvert	=		ty, Town or Lo Lusby	ocation						10d. Inside City Limits 1 ☐ Yes 2 No
th with the 23a or 28	at Director	10e. Street and Nu 2132 Das	mber sher Driv	<i>7</i> e			10f. Zip Code 2065	7		_	Citizen of the		*
be filed within 72 hours after death with the Maryland na! Hygiene. Id other then "natural", or items 23a or 28a-1 show event, the Michael Examination intified at	by Funeral	11. Marital Status 1 ☐ Never Mari	ried 2 Married	12. Was Deced Armed For 1 Types If Yes, Give Year or Da	ces? 2 □ No 196	01-	Was Decedent of I If Yes, specify Cub 1 Yes 20 No		(Specify Yes or ferto Rican, etc.)	No-		ck, White,	can Indian, etc. iite
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ould be filed Mental Hygi arked other atic event, I	To Be (17. Father's Name Edward A						18. Mother's N	ame (First, Midd Ester My	rtI	den Suman e Brov	ne) √ N	
ts DE E		19a. Informant's N Edward A					ng Address <i>(Street</i> Dasher D						Code)
permit. Pages 1 and 2 Depertment of Health a Important: if item 27 is eny injury or other tre once.		20a. Method of Dis	position	☐Removal from S	20b. F	Place of Disponentery, creametery, creametery	esition (Name of matory or other pla tan Crem	atory 4/	Date /27/06		c. Location -		own, State 'irginia
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Physician Medical Examiner M	cai Examiner	disease or condition resulting in death) Sequentially list configure in the cause. Enter Under Cause (Disease or that initiated eventuresulting in death)	onditions, nmediate arlying injury s	Due to (c	ongesti or as a conseq or as a conseq or as a conseq	quence of):	rt Failu	re					years
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To the Hospital or Attending Fra within 2 Hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	1 ♣ Watural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending investigati 6 Could not determine	be 28e. Place		Injury ome, farm, sti	Wo	rk?` Yes 2□No		(Stree	t and Numb		al Route Number,
Hospital or 24 hours afte Funerei Dir tely filled in I	ical Cer	29a. Certifier (Check only	Certifying F	Physician: To the laminer: On the ba	best of my kno	owledge deat	h occurred at the til	me, date and pla	ce and due to th	0 03116	o(s) and ma	inner as si	tated.
To the within 2 To the complet	Medical	29b. Signature and		and manne	er stated.		29c. Licens D142	se number		29d.	Date signed		
7-11		30. Name and addr		11									
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Registi	rar		APR 2	2 8 2006▶	Berein	is St.	Goale						



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Deloris J. Hawkins 9:20 A Apr 23, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 115 Goldstein Road Prince Frederick If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Dec 14, 1947 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 F Months Maryland 213-54-6761 58 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show other treumatic event, the Modical Examinar must be notified at Prince Frederick 1 TYes 2 No Calvert MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20678 U.S.A. 115 Goldstein Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married 1 □ Yes 2 No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Genatric Health Care Nurse's Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) to and 2 should be fit Health and Mental H Be Evelyn Parker Wilford Hurley ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 Month **Physician** 3:10 AM Edward Louis Hoeftman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Hospital Lanham Prince George's 8. Date of Birth (Month, Day, Year)
Feb. 2, 19 7. Age (In vrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F Days Hours Min. 220-20-0014 Director 1929 Pittsburgh, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23a or 28a-f ehov MD Prince George's Largo Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 600 Largo Road USA or Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. TYes 2 ☐ No Yes, Give 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ₩idowed 4 Divorced Year or Dates: "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Federal Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Thomas Edward Hoeftman Agnes Jane McNeelv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 le Rosemary Mason (Social Worker) P.G. County Dept. of Social Services Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) April 25 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 2006 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 23a. Patr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONONARY SYNDROME Physician /Medical as a consequence of): **Examiner** NAC PRICURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit death certificate be executed Due to (or as a consequence of) Box 68760 physicien Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
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this After **Division** Attending death. Director filled in by Hospital or 24 hours a

25. Was case referred to medical examiner' 1 ☐ Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

27. Manner of Death 1 Natural

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifier

1 riffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title

D58182

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

Hanover PKWY Green belt Md 20170 Cecil D. George MD 1305 A 31. Date filed (Month, Day, Year)

State Registrar

completely

within 2 the

Certification:

Medical

32. Registrans Signature APR 2 6 2006 Blown & Spelle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Amend Item #10c PerFH G855Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 2006 29, Esther Marie April 4:45A Hilton 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lorien Health Care Center Mount Airy
Under 1 Year | If Under 24 Hrs.
Onths Days Hours Min. Carrol1 8. Date of Birth (Month, Day, Year) Oct. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2√2F Months 220-24-4518 Maryland Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Howard Montgomery Maryland Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7135 Annapolis Rock Road 21797 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker School System 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Nimrod Harrison Mildred Marie Phoebus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith M. Curtis - Daughter 7134 Annapolis Rock Road, Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 Removal from State Tabor Cemetery * 4 Donation 5 Other (Specify) 5/2/06 Etchison, Maryland 21. Signature of Fureral Service Licenses Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Cancel Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery Month Day

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

Be

2

Funeral

Director

itam 27 is marked other than "natural", or itams 23a or 28e-f show other traumatic event, it e Madical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If itam 27 is marked other than "natural", or ita

itam 27

ō

Baltimore, Maryland 21215-0036

death with the Maryland

Examiner attending physician and for use as the burial-transit Physician/Medical been signed by the a should be detached t Š Completed Be 2 After thi funeral Certification:

requires that the death certificate be executed

To the Hospital or Attending Physicien:

Division of Vital Records, P.O. Box 68760

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown

2 Fetal death	3 □Ectopic pregnand
t time of death	5 □ Other (specify) _

Part II. Other significant conditions contril	outing to death but not re	esulting in the underlying	cause given in Part I.

23e. Did tobacco us	se cor	tribute to t	he cau	se of death?
1 ☐ Yes 2🛣	οNC	3 🗌 Prol	bably	4 □Unknow
24a. Was an autopsy performed?	24b.	death?		idings availab
1 ☐ Yes 21 No		1 Tyes	2 🗆 N	lo

(Street and Number or Rural Route Number

25. Was case referred to medical					
examiner? 1 ☐ Yes 2 ဩxNo		spital: 1 Inpatient	2	ER/Outpatient	3 🗆 D0
27. Manner of Death		28a. Date of Injury		28b. Time of	2

)A	Other:	4 ☑ Nursing H	ome	5 Residence	6 ☐Other (Specify)
28c.	Injury at		28d.	Describe how ini	ury occurred

26. Place of Death (Check only one)

1 Yes

21 No

Natural Accident	5 Pending investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No	250. 5000.15
☐ Suicide ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he	ome, farm, street	t, facto	ory, office		28f. Location

29a. Certifier	1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
one)	and manner stated.

29b. Signature and title of certifier	
11 4, 1	
1/1/1 4	U~ MO

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Type, Print) Aue St 307 Westminster MD 21157 31. Date filed 2006

State Registrar

Medical

			1 - For State Registrar	State of Ma	ryland	•	artmen tificate			and M		giene leg. No.	006	15196		
	Dhysisi	a n	1. Decedent's Name (First, Middle, Las	t)							Date of Dea Month	Day	Year	3. Time of Death		
	Physici /Medio		MYRTLE LOWENA	HUGHES							April	24, 2		9:05 p M		
7	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death		4c. Co	unty of Death	Death		
			Charlestown Re					onsv	ille If Under	24 Hrs	O Date of Diet		Balti			
	Funeral Director		215-50-1762	M 2⊠F	94	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day Nov. 3,	1911	Col	nplace (State or Foreign Intry) Itucky		
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits		
	72 hours after death with the Maryland naturel; or Iteme 23a or 28e-f show disal Examinat rout be rodified at	ō	Maryland Anne Aru	indo 1	F	dgewat	tor							1 ☐ Yes 2 ∑ No		
	1 the	Funeral Director	10e. Street and Number	inder		ugewa	10f. Zip	Code				10g. Citizen	of What Cor	untry?		
	3a o	0	950 South River	Landing				2	1037				U.S.A.			
	ms 2	Jer	11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S	S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer	ican Indian,		
9	or Ite	F	1 Never Married 2 Married 1 Yes, Give 1 Yes, Specify:								rican, etc.)		Black, White), etc.		
8	irel',	d by	3 ¼ Widowed 4 □ Divorced	Year or Dates:	WWII			222 140	эрвспу.			Spe	ecify:	Thite		
21215-0036	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced (Give	kind of wor	k done d	uring mos	t of work	ing	16b. Kind o	of Business/I	ndustry		
12	within ane. then	m d	Elementary/Secondary (0-12)	Callege (1-4or 5	+)		DO NOT us	,				**				
	filed Hygid ther	e C	17. Father's Name (First, Middle, Last)	-		Nurse	e Ane	stne		r's Name	(First, Middle,	Hosp Maiden Sur				
Maryland	d be sed o	To Be	William Edison						Nora		•		,			
<u>></u>	Shoul nd Mo mari mati	F	19a. Informant's Name/Relationship (Гурө, Print)		19b. Mailir	ng Address	(Street a			I Route Numbe	r, City or To	wn, State, Z	ip Code)		
M	nd 2:		Sonia Rita Hughes	- Daughte	- T	950 9	South	Riv	er T.a	ndin	g. Edge	water	MD 2	1037		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 le marked other then "naturel", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinational De Folling 21 and injury or other treumatic event.		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nan	ne of	1		Date		on - City or 1			
E	Page ient o nt: If ry or		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify				-			4/20	9/06	Adel*	hi M	arvland		
alti	mit. partrr porte y inju		4 □ Donation 5 □ Other (Specify) George Washington Cemetery 4/29/06 Adelphi, Marylan 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A.													
m	Depa Depa Impo any i		A Constance Gasch 4739 baltimore Avenue, Hyattsville, MD 207													
	P util		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused one cause on each lin	the death	. Do not ent	er the mod	e of dying	g, such as	cardiac o	or respiratory ar	est,		Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition		-	ment	115							Onset and Death		
	/Medical		resulting in death)	Due to (or as a	consequ	ence of):	1.	11.				T.				
	Examiner	_	Sequentially list conditions.	b	(00	1	Ve	HC	97+	t	-9,1c1	2				
-	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	efice of):										
	end end I-tran	хаш	that initiated events resulting in death) Last	c Due to (or as a	consequ	ence of):				-						
760,	certificate be executed ding physician end tse as the burial-transit	lical E				0.,,										
687	ficate phys s the	adic		d												
Вох	eath certifica attending ph i for use as th	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d.	Date of delin	very		
m.	death e atten	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🕅 No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pr Other (sp						Month	Day Year		
P.0	the ache	hys	9 🗆 Unknown	9□ Unknown												
	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions of	ontributing to death bu	it not resu	itting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use o		the cause of death?		
ord	equir en si ould I	ted									1 🗆 Y	es 2□N	o 3∏Pro	bably 4 TUnknown		
ecc	~ Q 70	pie									24a. Was a		4b. Were aut	opsy findings available ompletion of cause of		
Vital Records,	The law ate has page 2:	Completed									perfor		death?	2 🗆 No		
/ita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	112-1				-		of Death	(Check only or	16)	- TEO - C			
of	Phys this al di	To	1 Yes 20 No	Hospital: 1 ☐ Inpatie		ER/Outpatien			-11 140		me 5 Resid			ify)		
n C	ling F	lon	27. Manner of Death → Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? ∕es 2 🔲 I		28d. Describe h	ow injury oc	curred			
Sic	Attending r death. sctor: After y the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		inc. At hor	mo form str			res Z		28f Location (S	treet and N	umber or Rui	ral Route Number,		
Division	lor A after Direction by	Certification;	4 Homicide determined	building, etc	. (Specify)	eet, lactory	, onice			City or Tow	n, State)	3177001 07 7 141	ar rioute remoter,		
	To the Hospital or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of tiner: On the basis of and manner sta	examinati	wledge, death ion and/or in	n occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, th occurr	and due to the o	ause(s) and late and pla	I manner as ce, and due	stated. to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/			290	License	number		2	9d. Date si	gned (Month	, Day, Year)		
	> - 0	8		ND			1	14	744.)		April	75	2006		
R	(3) IV		30. Name and address person who	11		/	Print)	1511	110	,//	aglar		,			
′′	Sta	ate.	31. Date filed (Month, Day, Year)	2. Registra	r's Signat	ure 🕒			, ~	V *	, 1,					
	Registi		31. Date filed (Month, Day, Year) APR 2 8 2006	Men	K	Apa	E.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2006 1356 April 20 Mary Elizabeth Hilton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Days Hours Months **Funeral** 1 □ M 2 DXF Aug. 20, 1947 Wash. DC Director 577-62-6284 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City. Town or Location "natural", or iteme 23a or 28a-f shov salcai Exambar must be notified at N Yes 2 No Completed by Funeral Director Temple Hills Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 United States 6701 Geneva Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Federal Employee 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilma Lyles Franklin Hilton မ permit. Pages 1 and 2 shoul Depertment of Health and Milmportent: if item 27 is marleny injury or other treumations. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6701 Geneva Lane, Temple Hills, MD Renee Francis/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 4/27/2006 Washington, DC 4 □ Donation 5 XOther (Specify) Entombment Stewart Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic encephalopatty **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Honknown Seizun disorden 24b. Were autopsy lindings available prior to completion of cause of death? Cirebre vascular 24a. Was an autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No After this tuneral dir

attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760 hed by the a

Hospital or Attending Physicien:

i Director: / d in by the f

within 24 hours after d To the Funerel Direct completely filled in by

Medical

Baltimore, Maryland 21215-0036

2 Certification;

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier Rit Pul M.D.

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 T Homicide

Duzune

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. ROINTAN FARAH, FAR

9801 Georgia Ave suit 3-41 Silverspring To

State Registrar

32. Registrar's Sig 31. Date filed (Month, Day, Year) APR 2 7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Herman Fitz Maurice Henry April 18, 2006 8:49 P.M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | 8. Date of Birth | Month, Day, Year) | 1939 | 9. Birthplace (State or Foreign Country) | South | 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F Yrs. 578-76-7337 67 Guyana, America January 13, Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County worde. rai', or items 23a or 26a-f ehov Examinar must be notified at 1 Yes 2 □ No Silver Spring Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 9101 Second Street Guyana, South America death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 XNever Married 2 ☐ Married 1 ☐ Yes 2**X** No Specify. **Black** þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education years plus Educator Pages 1 and 2 should be filed v treen of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lelia Francina Dillon Joseph Nathaniel Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison Margaret York(Friend & POA) 1629 - 11th Place, N.E.; Washington, D.C. 20002 April 26,2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. Washington, D. C. 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 21. Sonature of Funeral Service License 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D..C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure Days /Medical Due to (or as a consequence of): Examiner Pneumonia Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Prostate Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death
To the Funerel Director:
completely filled in by the I 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2 7 2006

Suresh K. Gupta,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760,

DHMH 17 Rev 1/2001

32. Registrar's Signature

29c. License number

D-32332

M.D.; 9801 Georgia Avenue; Suite 220; Silver Spring, Maryland

29d. Date signed (Month, Dev. Year)

20902

April 19,2006

		For State Registrar	i icasc i		f Marylar	nd / Depa		t of H	lealth a		-		2006	1519	9	
Physic /Med	ical	Decedent's Name (Fire Clarence Ho 4a. Facility Name (If not all the contents of the c	usel, Jr.		mhar)				Location o		2. Date of De Month	Day		3. Time of Dea	ath M	
Exami		5. Social Security Number	1eart	Hozi	7. Age (In yrs.	last birthday)	If Under	me	If Under	QUA	8. Date of Bi	f	thee	ANY	reion	
Funeral Director		212-24-2357 Usual Residence of Dec	1)	(M 2□F	76	Yrs.	Months	Days	Hours	Min.	06-May	ay, Year)		nplace (State or Fountry) yland	- Gigit	
Marylan a-f ahow	ctor	10a. State 10b	. County Allegan	у		ty, Town or Lo	ocation				10d. Inside City Limi 1 ☐ Yes 2 🔀 1					
h with the 23a or 28 1st be no	Funeral Director	10e. Street and Number	18400 Oa	k Tree La	ne		10f. Zip	Code 532-				10g. Citiz	zen of What Co	untry?		
If 9, MIZITY IZITIO Z. I.Z. 15-0050 s. 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Middical Examinar must be notified at	₽	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐ 15.	Divorced Decedent's Edu	Armed For 1 Yes, Gir Year or D	2 □ No W	16a. Dece	Was Deced If Yes, spec 1 Yes	dent of Hi city Cuba 2 10 No	Specify:		cify Yes or No lican, etc.))- 1	Race - Ame Black, White Specify:	White		
within 72 ene.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) Spinning department								t of workin	g					
aryland A should be filed and Mental Hygis marked other umatic avent, I	To Be Co	17. Father's Name (First,	, Middle, Last)			spinn	ing dep	partmo	18. Mothe	Gord	(First, Middle		le manufa Sumame)	cturing		
and 2 sho eelth and 1 n 27 is ma		19a. informant's Name/F			ehter		ng Address Old Fros		and Numbe		Route Numb		Town, State, 2	ip Code)		
HOCE, M ages 1 and 2 ant of Heelth It: If Item 27 y or other tra		20a. Method of Disposition	on emation 3 🗆 F		State 20b. F	Place of Dispo cemetery, crer	matory or o	ther place	ө)	Da	ate	20c. Loc	cation - City or	Town, State		
Dattinor permit. Pages 1 Depertment of H Important: If its any injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Av.												aryland		
certificate be executed wing physicien and control of the purial-transit be as the burial-transit control of the purial-transit Ical Examiner	23a. Ant1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ure. List only o	Due to	each line.	PSIS juence of):		le of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Deatt			
death death death	Physician/Med	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	jnant	1 Live t	tcome of pregna birth 2 Teta nant at time of d own	ıl death 3□	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of deli Month	very Day Year		
Ords, F.C. requires that the een signed by th hould be detache	۵	Part II. Dther significent	conditions co	ntributing to d	eath but not res	ulting in the u	nderlying c	ause give	en in Part I.			obacco us		the cause of death		
1 RECOR	Completed	DEN	1ENTI	A							24a. Was auto perfo		24b. Were au prior to death? 1 \(\sum \) Yes	topsy findings avail- ompletion of cause	able of	
ysician: 'ysician: 'ysician: director, p	To Be	25. Was case referred to examiner? 1 Yes 2 No	-	lospital: 1 🔀	npatient 2	ER/Outpatien	nt 3 DC	Othe			(Check only o		☐Other (Spec	u(v)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certification:	2 Accident	Pending investigation		of Injury th, Day Year)	28b. Time of Injury	М			28	Bd. Describe	-				
tal or At irs after or at Direct led in by		4 Homicide	determined	build	of Injury - At he ng, etc. <i>(Specif</i>	y)					City or To	wn, State)		ral Route Number,		
the Hosp in 24 hou the Fune pletely fil	edical	29a. Certifier 1 2 Check only 2 one)	Certifying Phy Medical Exami	rier: On the b	best of my kno asis of examina ner stated.	owledge, death	h occurred vestigation,	at the tim , in my op	e, date and pinion, deat	d place, ar th occurre	nd due to the d at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)		
5/IVA	×	29b. Signature and title of	of certifier H	Choto	m' M	D		License	885	3			signed (Month			
MA		30. Name and address of HABIB C	f person who co	ompleted caus	se of death (Item	n 23a) (Type, PENN	Print) SYL	VAN	JA	AVE,	Cur	NBEI	RLAND	, MD 215	502	
Si Regis	tate trar	31. Date filed (Month, Da		6 32. 5	gistrar's Signa	ature	book	,								

December Name of Post Individuos, pion sense and monther) Sense				1 - For State Registrar	State of	Marylar				lealth and Death	Mental H	ygien Reg. N	ZIIIII	15200
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Second Second Number Color				4a. Facility Name (If not institution, g	give street and numb	oer)		4b. Cit	y, Town, o	Location of De				
Second Second Number Second Number Second Number Second Second Number S			147	Memorial Ho	spital				Cum	berland			Allega	ınv
2.19-34-725											rs. 8. Date of B	irth Day, Yea	r) 9. Birtl	nplace (State or Foreign
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The state of the s		petr Insit	듣	cause. Enter Underlying Cause (Disease or injury	,		, , .							
FFMALE 230. Was decedent pregnant in the past 12 months? 1 Yes 2 No North 2 Fefal death 4 Pregnant at time of death 4 Pregnant at time		execu n and al-tra	xal	that initiated events		as a consec	quence of):							
FFEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fefal death 3 Ectopic pregnancy Month Day Year 1 Year 2 No 3 Probably 4 Unknown 4 Probably	9	sicia buri	cat		d =									
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Duilding, etc. (Specify) City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	0	ng Pt ter th			28a. Date of (Month.	Injury Day Year)		f	28c. Injur					
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30. Name ddress of pers n o complet cause of death (Item 23a) (Type, Print) Beverly (a)/kins, M.D., 500 Memorial Avenue, Cumberland, MD 21502 State 31. Date filed (Month, Day, Year) 32. Register's Signature		rs aft	Se		. II							J, O.G	,	
30. Name ddress of pers n o complet cause of death (Item 23a) (Type, Print) Beverly (a)/kins, M.D., 500 Memorial Avenue, Cumberland, MD 21502 State 31. Date filed (Month, Day, Year) 32. Register's Signature		tospi t hou unai	cai	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the b	est of my kno	owledge, deat	h occurre	d at the tin	ne, date and pla	ce, and due to th	e cause(s) and manner as	stated.
30. Name ddress of pers n o complet cause of death (Item 23a) (Type, Print) Beverly (a)/kins, M.D., 500 Memorial Avenue, Cumberland, MD 21502 State 31. Date filed (Month, Day, Year) 32. Register's Signature		the hin 24 the f			and manne	r stated.					SOLIOU AL LITE LITTE			
30. Name ddress of pers n o complete cause of death (Item 23a) (Type, Print) Beverly (a /kins, M.D., 500 Memorial Avenue, Cumberland, MD 21502 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		T Will	-	29b. Signature and title of certifier	P	00	1	2					- '	
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State 31. Date filed (Month, Day, Tear) 32. Head mar's Signature Registrar APR 2.5.2006								cial	Aven	ue, Cum	berland,	MD	21502	
					2006	mars Signa	ature A	-	M =					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 28, Harmon Apri1 2006 1622 PM De 11 Denver /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/25/1954 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F Yrs. 467-13-9012 Director Texas 5 1 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important; if item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Madical Exercises. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Texas McAllen Hidalgo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 N. 8th Street 78501 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify δ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Inspector Gas & Oil Pipelines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vivian Vega L1oyd Harmon Darry1 ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 N. 8th Street, McAllen, Texas Darryl L. Harmon / father 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 Burial 2 N Cremation 3 Removal from State 5 ☐ Other (Specify) Cumberland Crematory 5/2/06 4 Donation Cumberland, MD 21. Signature Fun ral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Self-Inflicted Gunshot Wound to Head /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical the ettending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? certificete 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.
To the Funerel Director; After this certifice 25. Was case referred to medical examiner? Released 1 🕅 Yes 2 □ No Be 26. Place of Death Check only one Hospital: 1 🖔 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA s efter death. il Director; After this id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 No Subject shot self 2 Accident 04/27/2006 8:31 A 6 ☐ Could not be 3 X Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) Moorefie 215 Chipley Lane, WV determined 4 Homicide Moorefield, Driveway of Rental Residence 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier прletely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MW Dlesse May 2, 2006 D53158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

MRS

State

Michael Stasko, M.D.,

MAY 0 2 2006

32. Registrar's signature

31. Date filed (Month, Day, Year)

924 Seton Drive, Cumberland, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** HOLBUS VIRGINIA ROSE 25 2006 APRIL 21:49 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 11 1919 Birthplace (State or Foreign Country)
 Onio 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F Yrs. Feb. 87 296-07-3730 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Derwood 1 ☐ Yes 2 No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 6605 Hollingsworth Terrace United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 0 permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if flem 27 is marked oth any high of other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (Unknown) (Unknown) Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6605 Hollingsworth Terrace, Derwood, Md. 20855 Steven J. Holbus / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/06 Alexandria, Va. 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Tervice Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 20882 m-00470 Box 5038, Laytonsville, Md. P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A cute Renal /Medical Due to (or as a consequence of): と きらい Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Ceath 28b. Time of 28d. Describe how injury occurred 1 Z Naturat 5 Pending 1 ☐ Yes 2 ☐ No M 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Title of certifier

certificate be executed ettending physicien and for use as the burial-transit Box 68760 P.O. been signed by the should be deteched Records, this certificate Division of Vital Attending Physician: After thi or all or Ah.

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rthan "natural", or iteme 23a or 28a-f ehov Us Medical Examiner must be notified at

within 72 hours after

al Hygiene.

Physician

Examiner

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Snyder,

myth Mis

9901 Medical Center Dr., Rockville, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 35 PM Day Year 2006 amue 92 4a. Facility Name (If not institution give street and number) Baltimore Rehabilitation Extended Care Cent 4b. City, Town, or Location of Death 4c. County of Death Baltimor enter If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth May 3,1963 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2 ☐ F Months Texas 198-58-1239 42 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N☐Yes 2☐No Glen Burnie Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 309 Mountain Ridge Ct. #j 21061 United States 12. Was Decedent Ever in U.S. Agmed Forces? 11 □ Yes 2 □ No 8-1981 If Yes, Give Year or Dates: 1-1993 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify:White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ Morse System Operator Military 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harvey Earl Hess Virginia Mae Horn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Pepperdine Circle, Catonsville, MD 21228 Tammy Flaharty/ Spouse 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arlington National Cem 5-17-06 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility's Sons, INC Willia 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acour Due M r as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): pregnancy Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year e of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

Funeral

Director

Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygien6. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury pagiter traumatic event, fra Medical Examilier must be mutified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner ettending physicien end for use as the burial-transit cate has been signed by the page 2 should be detached Be Completed by ours after death.

neral Diractor: After this certifical filled in by the funeral director. Certification: To

Hospital or Attending Physicisn: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 l 4 □ Pregnant at tin 9 □ Unknown
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 ER/Outpatient

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes

1 ☐ Yes 2 🔀 N	lo	Hospi	tal: 1 🗌 Inpatient
7. Manner of Death 1 Anatural 2 Accident	5 Pending investigation	28	Ba. Date of Injury (Month, Day Yea

Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAD

2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29c. License number D36508

Baltimore

3900 Loch Raven

29d. Date signed (Month) Day, Year) 24, 2006 Boulevard

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29a Certifier

32. Degistrar's Signature MARKET

State Registrar

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31. Date filed (Month, Day, Year) APR 2 8

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		•	For Stete Registrar	State of M	arylan				ealth a		-	giene Reg. No. 20	06	M	5205	
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<u>)</u>	Examir		4a. Facility Name (If not institution, give Washington County	Hospital				Hag	Location	own	7	Was	4c. County of Death Washington 9. Birthplace (State or Foreign			
	Funeral Director		5. Social Security Number 6. S 213-16-1263	iex 7. Ag	91	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da Sept.	v Year)	Cou	intry)	itate or Foreign	
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	Funeral Director		5// 28 2//6	ex 7. Age (In yrs. 8	2 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) MAY 30,	th, Year) 9. Birthplace (State or Fore Country) VIRGINIA				
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10	0d. Inside City Limits		
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5-0036	should be filed within 72 hours after death with the Maryland and Manall Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show matic event, the Macing Examiner must be notified at	by Funerai	11. Marital Status 1 ™Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 23 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	White, 6	etc.		
2-0	"natur	Completed	15. Decedent's E (Specify only highest gra		16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Bus	b. Kind of Business/Industry			
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0	Hygid other	BeC	17. Father's Name (First, Middle, Last				18. Mother's Nan	ne (First, Middle, i	Maiden Sumame)			
0	Aental Aental rked o	To B	JOSEPH H	ENRY JOHNSON			BERNI	CE BANKS					
Maryland 2121	permit Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic ev <u>0069</u> .		19a. Informant's Name/Relationship (BERNICE M. JOH)	C. 2001	_ ' '								
Baitimore,	of Hea of Hea fitem		20a. Method of Disposition	Bemoval from State	Place of Dispo cemetery, cren	sition (Name of matory or other place		Date 20c. Location - City or Town, St.					
Ě	Pag ment ent: ury c		*4 Donation S Other (Specify) FT. LINOCLN CEM. 4/29/2006 BRENTWOOD, MD.										
a D	permit Depar Impor any in		21. Signature of Funeral Service Lice	nsee/		. Name and Addres					- HOPIE		
80			23a. rt1. Enter the disease, or corr	plications that caused the lea							Approximate		
3	Physician		shock, or heart failure. List only Impudiate Cause (Final	CHRONIC OB	STRUCTI	EVE PIILMO	NARY DIS	EASE			Onset and Death YEARS		
	/Medical		disease or condition resulting in death)										
	Examiner		Esquardially list conditions,	CORONARY A	RTERY I	DISEASE							
٠	p t	iner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of):										
	and -trans	Examiner											
5876U,	ficate be executed g physician and as the burial-transit	aiE		200 10 (01 00 0 001001	4201100 01).								
280	ficate g phys	edicai		_ 0									
P.C. Box	The law requires that the death certific te has been signed by the attending for tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown							23d. Date of delivery Month Day Yea			
ds, F.	uires that the de i signed by the a id be detached f	by	Part II. Other significant conditions	contributing to death but not re	en in Part I.		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow						
000	aw requir as been si 2 should	Completed						24a. Was a		ere autor	psy findings available		
Ĕ	The lay	mo		-				autops perform	med? de	or to cor ath? ⊒Yes	npletion of cause of 2 No		
<u> </u>	i cien : Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Dea	ith (Check only or					
>	ysic lis ce	To	examiner? 1 □ Yes 💥 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Reside	ence 6 Other	(Specify	/)		
0	Attending Physicien: r death. ector: After this certific. by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No		ow injury occurre				
<u> </u>	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	20/ 1		0	/ Oc. 45 At						
Division of Vital Records,	or Attendated after death	Certification:	4 Homicide determined	City or Town	treet and Number n, State)	or Hura	I Houte Number,						
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Medical C		nysician: To the best of my kn miner: On the basis of examin and manner stated.									
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	_		29c. Licens	e number	2	9d. Date signed	(Month,	Day, Year)		
			Ton	neller m	8		D30272		APRIL 2	5, 2	006		
)_			30. Name and address of person who							•			
			THOMAS S. MILLES 31. Date filed (Month, Day, Year)	R, M.D., VA MA		HEALTH C	ARE SYSTI	EM, PERRY	POINT,	MD	21902		
	Sta Regist		MAY 0 1 200		April 1	ale .							
DH	MH 17 Rev 1/2	001											

			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death		74 4 4 6 0	15208
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	. No.	3. Time of Death
	Physici		Ronald Walter Jones JR	April	25, 2006	1775 - M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			Dorchester General Hospital Cambridge	e	Dorch	ester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo	ear) 9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent	Oct, 21,		aryland
	nand ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Man a-f sh	tor	MD Dorchester Cambridge			1 Pres 2 □ No
5	with the Maryland ie or 28a-f show i be notified at	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	intry?
Ź	ath wi		530 Leonards Lane 21613		USA	
3	tems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by F	1 Never Married 2 12 Married 1 Yes 2 12 No 11 Yes 2 12 No 11 Yes 2 12 No 11 Yes 2 12 No Specify: Year or Dates:		Specify: 21	ack
21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "netural", or items 23e or 28a-f show of other than "netural", or items be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business/li	
215	within 73 ene. than "n	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	ing		,
2	e filed within at Hygiene. other than '	Som	9 Carpenter	0	Self Emp	ployed
nd	be filk tal Hy d oth	Be		(First, Middle, Mai	iden Sumame)	
<u>yla</u>	2 should be and Mental is marked eumatic ev	Ţ	Ronald Walter Jones, SR. Bett	y Huc	Son	
Maryland	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)	. 2	tity or Town, State, Zi	21643
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other treumatic		Betty Warner 5902 Jeans Dr. 20a. Method of Disposition (Name of cemetery, crematory or other place)	Hur/c	c. Locution - City or T	wn. State
Baltimore,	Pages nent of int: If it		1 Burial 2 ØCremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Share (Venn ton) 4/2	8/06 1	0.0000	415
Ħ					ambridg	e ND.
ã	permit. Departr Importa any inji		Janelle C. Henry Funeral H 510 washington	TOME, P. A.	bridge A	10.21613
			23a. Paky. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest	. 977	Approximate Interval Between
j.	Physician		Immediate Cause (Final disease or condition Act of Static Colom Carcinome			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	-1		7 69
	LAdillillei	_	Sequentially list conditions, b.			
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	al-trai	xan	that initiated events c			
8760,	icate be executed physician and s the burial-transit	dicai E	d			
9	tificat ng phy as th	ledi				
Вох	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of deliv	
	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
P.0	that the dead by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 Did tobac	co use contribute to	the equipped of death?
ds,	S U 0	d by	and the significant containing to death but not resulting in the underlying cause given in Part i.	1 ☐ Yes	2 No 3 Pro	
Records,	> 0 0	Completed		24a. Was an	-	
Re	e lav	dmo		autopsy	prior to co	opsy findings available empletion of cause of
Vital	iclen: Th certificate rector, pag		25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2	DNo 1 ☐ Yes	200
<u> </u>	S 0 : I	To Be	examiner?		e 6 □Other (Speci	fv)
J of	ng Phys ter this neral di	L: uc	27. Manner of Death 28a. ate of Injury 28b. Time of 28c. Injury at 2	28d. Describe how		,,
Siol	Attending r death. ector: After by the fune	catic	2 Accident investigation M 1 Yes 2 No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	Hospital		29a. Certifier VCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place a			
	To the Hospital or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 29a. Certifier (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence at the time, date and place. a page manner stated.	and due to the caus ed at the time, date	e(s) and manner as s and place, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
}			1 Tryen Ven 00 451793		4/25/0	\mathcal{C}
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 1-		,
			Zugene Newmier DQ 503 Bym It Cambri	age M	V 2/6/-	5
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 2006 32. Segistrar's Signature	/		

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1:15 P M Wendy Lawton Jackson April 25 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1645 Carriage House Terrace #I Montgomery White Oak Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, July 3, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Y°1963 Months Days Hours 1□M 2以F 42 wash. D. C. Director 579-94-9969 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show ust be notified at 1 ☐ Yes 2√ No Director Montgomery White Oak MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 U. S. A. 1645 Carriage House Terrace, #I ltems! 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 11. Marital Status the Medical Examiner: Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Receptionist 12 should be filed w and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Greene Everette A. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s' of Health a' fitem 27 i Barbara Jackson - mother 17000 Norbrook Dr., Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
important: if iter
any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crem. 5-2-2006 Alexandria, VA ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bell and Johnson Funeral Home, P. dure of Funeral Service Ligenses 6503 Old Branch Ave., Temple Hills, MD 20748 23a. Ant. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final minutes Physician a Acute Respiratory Distress Syndrone Due to (or as a consequence of: disease or condition resulting in death) /Medical Examiner Chronic Bronchial Asthma years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown History of Nicotine Addiction (remote) Uncertainty as to recent usage 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√ No has certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Division 1 🛮 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours ell To the Funaral D completely filled i Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier The N D0009215 April 27, 2006 wience 2 Lus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence D. Marcus, M. D., 10313 Georgia Ave., Suite 207, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Vear Curtis Jackson 2:35 P^M April 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1∰ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 579-26-8642 81 Yrs. Sep. Director 19, 1924 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23s or 28e-f ehow The Medical Exp. plant be notified at 1X Yes 2 □ No Directo Maryland | Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7904 Steve Drive 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk Government ith and Mental Hygie 27 is marked other if treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruffin Jackson ဂ္ Selena Coward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent; if Item 27 Is
any Injury or other treu 7904 Steve Drive, Forestville, MD 20747
Date 20c. Location - City or Town, State Naomi Jackson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2006 Brentwood, MD 21. Signature of Fuheral Service Licenses 22. Name and Address of Facility Stewart Funeral Home Steward 4001 Benning Rd., NE Wash., DC 20019 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) CARDIAC **Physician** /Medical Due to (or as a consequence of) Examiner scale titally fall conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 本Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the inector, page 2 s 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific dompletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manger stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

filed within 72 hours after death

Pages 1 and 2 should be

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) APR 2 7 2006 2006

30. Name and address of person

WENDELL



completed cause of death (Item 23a) (Type, Print)

06-02919 Kelvin Lin Jones

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Decedent's Name (First_Middle.Last) 3 Time of Death Physician/ Month Day April 30, 2006 JONES 1915 hrs **Medical Examiner** KELVIN LIN 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Frederick** Frederick 1708 Heather lane 5. Social Security Numbe 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Min Director 214-76-7705 Country) MD. 28-6, M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 4 IIV 10a. State 10b. County FREDERICA MD BRUNSWICK 1 Yes 2 No or items 23a or 28a-f show Baltimore, MD 21215-0036

permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country 21716 VS 8 AVE MAPLE Funeral Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes BLACK 1 Yes 2 No If Yes, Give Year 3 Divorced specify: Specify ۾ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+ KLSTAURANT SCRVCR 11 Tit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RICHARD MARIE JONES Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1336 TANKY AUG ADT 203 FREDORICK MD DAWSON MUTHOR MARIL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State 5-5-06 MD FREDBUCK SUMMY SIDE UMC COM. 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22, Name and Address of Facility FUNCTURE HOM South 21701 Jun J. FLOORICE 51 29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Narcotic intoxication and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED item#2,23a,27,28a-f,perME,g855,5/18/06 TI attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown been signed by the should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of has page 2 s performed? death? No After this certificate Yes 2 ✓ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death 28c Injury at Work? Certification: Natural 5 Pending 1 Yes 2 X No Funeral Director: hours after death Fnd 4/30/2006 Fnd 7:00 PM Investigation Accident 28f. Location (Street and Number or Rural Route Number. City or Town, State) 1708 Heather Lane Frederick, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide (Specify) House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only To the 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E May 1, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Aay, Year) 9 2006 strar's Signature State Registrar

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of Hertificate of L		ental Hygie	2000	15212			
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	/Medic		4a. Facility Name (If not institution, given			4b. City, Town, or	Location of Death		4c. County of De	ath			
			DOCTORS COMM	UNITY HOSP	ITAL	L	MAHKA		PRINCE	GEORGE'S			
	Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	irthplace (State or Foreign			
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	shov	_	10a. State 10b. County		roc. City, rown or Lo					1⊠Yes 2 No			
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	er de tems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh				
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d 2	1, 19 g	ပိ	17. Father's Name (First, Middle, Las	t)				(First, Middle, Mai	fiddle, Maiden Surname)				
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ž	nd 2 lith a 27 is r trau		Evelyn Bradsha	w/Daughter	9106	Hardesty	Drive	Clinton,	Md. 20	735			
Baltimore,	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. Place of Dispo	-			c. Location - City of	or Town, State			
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	mysician /Medical	1	disease or condition resulting in death)	-	D ABDOMINA a consequence of):	L AORTIC	ANEURYSM						
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	deat	Physician/M	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{Xio}\)	4☐Pregnant at 9☐Unknown		Other (specify)			Month	Day Year			
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death		- l				
of V	S D	2	1 ☐ Yes 2XXVo	Hospital: 1 Inpatie	ent 2 X ER/Outpatier	nt 3 DOA Othe	er: 4 🗌 Nursing Ho	me 5 🗌 Residenc	e 6 □Other (Sp	ecify)			
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	To the H within 24 To the F complete	Medical	one)	and manner sta		29c. License				``			
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2				- vu		D411	.82		April	25, 2006			
1	[7]		30. Name and address of person who				11 4 27 1	20 00	010				
			Felton Anderson 31. Date filed (Month, Day, Year)	2 Pegistr	06 Irving S ar's Signature		14 Wash	, DC 20	010				
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	Physicia /Medic		1. Decedent's Name (First, Middle, PAVLINE		KIM			2. Date of Death Month PRIL	Day Year 6	3. Time of Death				
	Examin ——— Funeral		4a. Facility Name (If not institution, RANDOLPH HIL) 5. Social Security Number	L NURSING		4b. City, Town, or WHEAT(N If Under 24 Hrs		4c. County of Death MONTGOMERY of Birth nth, Day, Year] 99. Birthplace (St Country)					
	Director		214 60 7461 Usuel Residence of Decedent 10a. State 10b. County	1□M 2XF	84 Yrs.	Months Days	Hours Min.	DECEMBE	R 26,	KOREA d. Inside City Limits				
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: if Item 27 is marked other then "naturel', or Items 23a or 28e-f show any injury or other traumelte event, the Medical Evair and institle trofilled at once.	by Funeral Director	4011 RANDOLPI 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	No	20902 Was Decedent of Hi If Yes, specify Cuba		 	USA					
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al Record	The law ate has b page 2 s	Completed			24a. Was an autopsy performed	prior to completion of cause of								
Division of Vital	or Attending Physicien: Thater death. Director: After this certificate Lin by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1											
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)	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		2	29c. License	number 00021033		Date signed (Month, D					
	(3)		30. Name and address of person via 13000 GEORGIA	A AVENUE,	death (Item 23a) (Type	r int)		0906						
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 1 20	D6	rar's Signature	E)								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 10:25 PM 29 2006 Martin J. Kostelec April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6406 Beechwood Drive Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Oct 16, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Director 201 16 4385 79 1926 Pennsylvania Usuat Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Martical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6406 Beechwood Drive 21046 Hems 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1X Yes 2 No 1 Never Married Married Baltimore, Maryland 21215-0036 ò If Yes, Give Year or Dates:1944–46 1 ☐ Yes 2/2 No Specify: Specify: þ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: if item 27 is markad other then Chief Engineer of T.V. Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Kostelec Katherine Ivec 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie J. Kostelec/Wife 6406 Beechwood Drive Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 1 4 □ Donation 5 □ Other (Specify) St. Louis Cemetery 5-4-2006 Clarksville, MD 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ed by tha attending physician detached for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown The law requires that the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an has autopsy performed? certificate 1 Tyes 2 TxNo or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ▼ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury t**X** Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours at To the Funeral D Hospitai filled 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOO ARINORY Suite 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar HAY A 9

			1 - State Registrar	State	of Marylar	•			ealth a D <i>eath</i>	and M		giene _{Reg. No}	200		152	16	
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	shysic this ce al dire	To	1 ☐ Yes 2 🛣 No			ER/Outpatien			4 🗀 (40)	rsing Hor	ne 5 🗆 Resid	ence	6 □Other (S)	oecify)			
Ė	ding Ph h. After th funeral		27. Manner of Death 1 △Natural 5 □ Pending	28a. Date (Moi	of Injury oth, Day Year)	28b. Time of Injury		28c. Injury Work			28d. Describe h	ow inju	ry occurred				
<u>s</u>	Attendid death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 1								
Division of	if or Attending Physician: effer death. Director: Affer this certific d in by the funeral director,	Certification:	4 Homicide determined	28e. Ptac build	e of I <i>n</i> jury - At h ling, etc. <i>(Speci</i>	iome, farm, str fy)	eet, factor	y, office			28f. Location (S City or Tow	treet ar n, State	nd Number or a)	Rural Ro	oute Numb)8 <i>1</i> ,	
_	Hospital 24 hours e Funerai D		29a. Certifier 1 Certifying Phy	sician: To th	e hest of my ke	nwledge doct) Occurre	at the #i-	le date ac	d place	and due to the -	ause/s	and mass:	ac elete	d		
	24 h 24 h Fun etely	Medical	(Check only 2 Medical Exami	ner: On the I	pasis of examination	ation and/or in	vestigation	i, in my op	pinion, deat	th occurr	ed at the time, o	ause(s	d place, and d	ue to the	a cause(s)		
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29	c. License	number		2	29d. Da	te signed (Mo	nth, Day	, Year)		
6			> Rehame	PU	ang	1	Т	60826			Α.	PRTT	28, 200)6			
(3		30. Name and address of person who co	ompleted cau	se of death (Ite	m 23a) (Type,		50020			A		20, 200				
_			GARG KSHAMA, M.D., 15	00 FORE	ST GLEN R	OAD, SIL	VER SI	RING,	MARYL	AND 2	0910						
	Sta		31. Date filed (Month, Day, Year)		Registrar's Sign	ature	certa	,									
	Registr	ar	MAY 0 1 2	006	Palus.	May 1	Anna - Charles										

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Thomasa Francis Lanier 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 0604 hrs May 4, 2006 Medical Examine LANIER THOMASA FRANCES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 6827 Forest Terrace Landover 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Days Months Hours Min. NORTH Director MAY 28 1959 CAROLINA 216-70-8183 1 M 2**X**_F Yrs Usual Residence of Decedent any 10a State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once. 1 X Yes 2 No Landover Prince George's Md Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g Citizen of What Country 10e. Street and Numbe 20785 U.S.A. 6827 Forest Terrace Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Black f Yes, Give Year Yes 2 X No specify: Widowed Divorced Specify. 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Private Child Care Provider 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hannah Dawson Be Jessie Franklin Lanier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6827 Forest Terrace Landover, Maryland 20785 Danyell R. Lanier 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/11/2006 Landover, Maryland rtment c Harmony Cemetery Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licens J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease, or complicatio **Physician** failure. List only one cause on each line Between Onset and /Medical Death Dilated cardiomyoipathy Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and tran. cal item#23a,27,perME,g856,6/20/06 TT tending physician a XUNPENDED AMENDED ician/Med Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) has been signed by the att 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 🗸 Other: Scene this Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural Pending Yes 2 No Director: d in by the f hours after death. Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical To the 1 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and marrier stated 29b/Signature apg 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E May 4, 2006

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

eted cause of death (Item 23a)

Assistant Medical Examiner

30. Name and address of person who complete

Susan Hogan MD. Y 1 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Laura Lykes 2006 /Medical pri 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctors' Community Hospital Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/28/1953 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 K Director 197-40-2228 Yrs 52 Teaneck, Usual Residence of Decedent 10a State 10c. City, Town or Location item 27 is marked other than *natural; or items 23a or 28a-f show other traumatic event, the Madical Exerciter must be notified at 10d. Inside City Limits XXYes 2 □ No Director Prince George's MD Lanham 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6713 Lamont Drive Funeral 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 Yes 2 No If Yes, Give X Year or Dates: Specify White 1 Yes 2 No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other than any injury or other traumatic event, than one. Administration Assistant Washington Times 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wilson Laura Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorman Lykes (Husband) 6713 Lamont Dr. Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)_ Fort Lincoln Cemetery 5/3/2006 Brentwood, MD 21. Signature of Funeral Service Licen ee 22. Name and Address of Facility Fort Lincoln Funeral Home 11 3401 Bladensburg Road cenas Chom Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic thyroid cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physicien and the burial-transit Pneumonia Due to (or as a consequence of): Physician/Medical Sepsis IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12-months? 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Metastasis to the lungs 2 X No Be Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 Yes 2 No 3√□ No 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2XXNo 1 🛚 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attending Physician: The law requires thet the death certificate be executed Box 68760, use as t ò P.0. detached Division of Vital Records, page 2 should funeral director, efter death. filled in by 24 hours To the I within 2

the Maryland

Meklie Worknem 31. Date filed (Month, Day, Year) State

one)

29b. Signature and title of certifier



accress of person who completed cause of death (nem 25a) (Type, Print)

Registrar MAY 0 2 2006



MD

29c. License number

DOO 62116

Greenbelt, MD 20770

29d. Date signed (Month, Day, Year)

4/28/2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 Physician John Clifford Lavinder April 3:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye. June 9, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Virginia Director 227-34-3740 75 1930 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be rightled at 1 ☐ Yes 2X No Maryland Prince George's Brandywine Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6112 McKay Drive 20613 death 1 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itsm 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Fundamentants. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Ď Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Explosive Ordnance Technician NOS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irvin W. Lavinder Annie K. Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles I. Lavinder/Son 1000 Concord Court, Owings, Maryland, 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns May 1, 2006 4 □Donation 5 □ Other (Specify) Waldorf, Maryland 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility M00053 3035 Old Washington Road Huntt Funeral Home POB 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 TUnknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 NO Hospital or Attending Physician: 44 hours after death. Funaral Director: After this certifica After this certific funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) operson who completed cause of death (Item 23a) (Type(Print) 30. Name and address 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Year A8911 27 3:45P **Physician** LIVINGSTONE Frances /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Wilson Health Care Center, Asbury Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 22, 19523 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Prinois 82 339-18-2888 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Items 23s or 28e-f show the Medical Examinational be notified at 1 N Yes 2 No Director Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20879 Framingham death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "neturel", or Item any injury or other treumation. 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Real Estate Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Florence Milton Cuttle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code)

1 Framingham Court, Gaithersburg, MD 208/9 19a. Informant's Name/Relationship (Type, Print) Diane Soroka / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Park April 30, 2006 Olney, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Turier Fervice Licensee) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION
Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical DEMENTIA **Examiner** Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death esn 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day 5 Other (specify) detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ WITH FEEDING TUBE PLACEMENT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ODA Other: 4 Mursing Home 5 Residence 6 Other (Specify)
28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marlene J. Har 06 031362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marlene Hayman, N. FREDERICK AVE. GAITHERSBURG MD 31. Date filed (Month, Day, Year) #egistrar's Signature State MAY 01 2006 Registrar about 1

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

1. Aprile

32 Registrar's Signature

	an	1. Decedent's Name	1_e							2. Date of Month	Da	04	Yeer	3. Time of De
/Medic xamin		4a. Fecility Name (If r			nber)		4b. City, Tow	m, or Locati	on of Dea		40	. County o	f Death	10.10
		Deer's	Head !	tospita	1 Cen	ter	Sal	lisbu	ry			Wic	200	rico
neral ector		5. Social Security Nur 227-76-29	16	Sex 1 □ M 2 □ x F	7. Age (In yrs 88	s. last birthday, Yrs.		ear If Und	der 24 Hr rs Mir	8. Date of (Month) 01/20	Birth , <i>Day</i> , Year) /1918		9. Birthple Count	
		Usual Residence of D	Decedent 10b. County		10c. C	City, Town or L	ocation						10	ld. Inside City L
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1289	rec	10e. Street and Numb	ber				10f. Zip Cod				10g. Ci	tizen of Wh	hat Count	ry?
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item 27 ie markad otner nen "natural, or iteme 23e or 28e-i show other traumatic event. The Medical Examinar must be notified at	t by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	_	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	rces? 2 XNo re	U.S. 13.	Was Decedent If Yes, specify C			Specify Yes or rto Rican, etc.	No-	14. Race	- America , White, e	tc.
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nt.		17. Father's Name (F	irst, Middle, Last	t)		l B	ookkeep		ther's Na	ame (First, Mic		Seafo		
lc ev	To Be	James	Henry	Nelson						phine	Law		,	
aumai aumai		19a. Informant's Nam	ne/Relationship ((Type, Print)		19b. Maili	ing Address (Str	eet and Nur	nber or F	Rural Route Nu	mber, City	or Town, Si	tate, Zip (Code)
er tra		Jill1	McCabe	(Daught	er)	P.0	0. Box 3	3402 -	Sal	isbury	. MD 2	21802		
	150	20a. Method of Dispo		•	20b.	Place of Dispe	osition (Name of matory or other	f		Date	20c. Lo	ocation - C	ity or Tow	
njury or		1 □ Burial 2 ☑ 1 □ Donation 5			Sa		y Cremai		05	/05/20	06 Sa	alisb	ury,	MD
any njury or		21. Signature of Fune Mary		nsee pe cadshaw	er DVR Pruitt	B i	2. Name and Ad radshaw	& Sor	cility Cr 1s Fu	isfield meral	d, MD Home,	2181 306 T	7 W. Ma	ain St.
		shock or heart	disease, or com	iplications triat ca				4 *	4.5					
dical		Immediate Cause (Fi disease or condition resulting in death)	tallure. List only	a. Cor	ach line. GEST OLAS a conse	ive t	1	Fail	ure					
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		1 - For Amend Item Registrar		درس وست	'Certifica	ite of L	Death		Reg. No.			
sicia	an	Decedent's Name (First, Middle, Las	t)					2. Date of De Month	ath Day	Year	3. Time o	
edic		Sandra Lee Lyter						4	26	2006	2:34	P M
min	er	4a. Facility Name (If not institution, give					Location of De	ath	4c. (County of Deat	h	
_		5. Social Security Number 6. Se		Rd • e (In yrs. last b		ckton	If Under 24 H	rs c Data at Dia		Worces		
ral tor			M 2⊠F	55	Yrs. Month		Hours M		v. Year)	9. Bin	hplace (State :	or Foreig
,		Usual Residence of Decedent		JJ				0/11/	1930		IN	
		10a. State 10b. County		10c. City, Tox	wn or Location						10d. Inside C	City Limit
	Ş	MD Worces	ster	Sto	kton						1 🗆 Yes	2. ∑ No
	Director	10e. Street and Number				Zip Code			10g. Citiz	en of What Co	untry?	
	ai	6003 George Island	d Landing	Rd.	2	1864			υ	JSA		
	by Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was De	pedent of His	spanic Origin?	(Specify Yes or No erto Rican, etc.)	- 1	4. Race - Ame Black, White	ncan Indian,	
	포	1 ☐ Never Married 2 X Married	1 ☐ Yes 2X N If Yes, Give	10		2€ No	Specify:	0.10 7.102.1, 0.0,			hite	
	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Specily. W	ште	
	Completed	15. Decedent's Edi (Specify only highest grad		168	Decedent's U: (Give kind of	vork done di	uring most of v	vorking	16b. Kin	d of Business/	Industry	
	E C	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NO1	•			T.T			
	ပိ	17. Father's Name (First, Middle, Last)	1		Grant Ad			ame (First, Middle,		ester	County	
	Be								Maiden S	sumame)		
	ဥ	Charles Herald	iona (Brint)	10	5 A4-10- A 14-	(0)		s Hall				
1		19a. Informant's Name/Relationship (T	ype, Print)					Rural Route Numbe				
1	- 1	Jeff Lyter 20a. Method of Disposition			0003 Geo		sland l	anding Ro		Stocktor ation - City or		<u> 21864</u>
1	. 1	1 ☐ Burial 2 ☐ Cremation 3 ☐ I		cemete	ery, crematory o	r other place				•	•	
ı		4 Donation 5 Other (Specify,		cape F	lenlopen			27/2006				
		21. Signature of Funeral Service Licens	7					The Burba			Home	
I		- Jun G	netale	-				Berlin, N		811		
ı		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on fach lir	the death. Do	not enter the m	ode of dying	, such as card	ac or respiratory ar	rest,		Approximat Interval Bet	tween
ı		Immediate Cause (Final disease or condition	a GUN	15407	WOU	ND TO	O KEA	D			Onset and	PATA
ı		resulting in death)		consequence							100000	
ı		Saquentially list conditions if any, leading to immediate		CIDE							mmzo1.	ATE
1	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
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ı	dicai		d									
ŀ	Physician/Me	IF FEMALE:	23c. If yes, outcome	of progpage.								
	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal deat					23	3d. Date of deli Month		Year
1	ysic	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4☐ Pregnant at 9☐ Unknown	time of death	5 Other (specify)					- 4,	
	占	Part II. Other significant conditions co	ntributing to death bu	it not resulting	in the undertying	Callee diver	n in Part I	23e Did to	phacen us	e contribute to	the cause of o	doath?
-	b S		.		o arraony mg	ou uso gira	THE LATER.		es 278		bably 4 🗆	
	ete											
1	Completed							24a. Was autop	sv	24b. Were aut prior to c death?	topsy findings completion of c	available ause of
								1 ☐ Yes	med? 2X No		2□ No	
П	Be	25. Was case referred to medical examiner?	Hospital:			! Other		eath Check only o	ne			
П	ို	Yes 2 No 27. Manner of Death	1 🗆 Inpatre		utpatient 3 1		+ Li Nul Siliy	Home 5 Resid				
	<u></u>	1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	Time of Injury	28c. Injury		28d. Describe h	ow injury	occurred 55	F INFELL	(75)
1	cat	2 Accident investigation 3 Suicide 6 □ Could not be	4-26-		1:34 PM		es 2 No			UND 70		
		4 ☐ Homicide determined	28e. Place of Inju building, etc	. (Specify)	at home			28f. Location (S City or Tow	n, State)	Number of Hu 263 Osb	iscano	RD
	Ē							5700	KTON	MD,		VAIKA
	i Certification:	20a Codifier	SICIAN' To the best of	t my knowledg examination a	e, death occurre nd/or investigation	d at the time on, in my opi	e, date and pla nion, death oc	ce, and due to the c curred at the time, o	ause(s) a date and p	nd manner as lace, and due	stated. to the cause(s	s)
		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of								,-	
	Medical Certif	one) 2)3 Medical Exami	ner: On the basis of and manner sta	ted.		On Lineanne	number)0d D-1:	signed /htm:	Day Ves	
		29b. Signature and title of certifier	Iner: On the basis of and manner sta	ted.	2	9c. License			≥9d. Date	signed (Month	, Day, Year)	
		29b. Signature and title of certifier	mer: On the basis of and manner sta	21 D ,						signed (Month	•	
		29b. Signature and title of certifier	mer: On the basis of and manner sta	M. Å , path (Item 23a)		1	06241	y 55 5	04-	-27-0	6	

State

Registrar

MAY 0 2 2006

		1	State of Maryland / Department of Healt State of Maryland / Department of Healt Certificate of Dea			ene	36	15226
	sicia edica	n	1. Decedent's Name (First, Middle, Last) Carl Sumpter Livesay		2. Date of Death Month 0 4	Day 2 7 2	Year 006	3. Time of Death
	mine	er '	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local 3233 Harney Rd. Apt D Taneyton			4c. County	of Death	
Fune Direc			213-24-7620 1 [‡] M 2□ F 78 Yrs. Months Days Hot	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 01/22/	1928	9. Birthp Coun VA	
Maryland -f show	18 755		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Carroll Taneytown				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
vith the	100	Direc	10e. Street and Number 10f. Zip Code		10	g. Citizen of	What Coun	try?
5-0036 72 hours after death with the Maryland "netural", or Itams 23a or 28e-f show	ZOL-III OLI III MAT	by Funeral Director	3233 Harney Rd. Apt D 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 21787 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	nic Origin? (Spe lexican, Puerto F pecify:	cify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, by: Wh:	etc.
– c * 4	T MEDICAL E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during life. DO NOT use relired) Upper Cutter	g most of workir	ng	Shoe		•
Ind be file doth doth	e ven	Be	17. Father's Name (First, Middle, Last) 18. M		(First, Middle, M	faiden Sumar		<u> ZI y</u>
0 0 00	anmati	္	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N					
s 1 ar	y or other traumatic	-	Nancy Lee Livesay Wife 3233 Harney Ro 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Carroll Cremation	D	ate 2	20c. Location	- City or To	wn, State
baltimo permit. Pages Department of Importent: If it	any mjur	Ī	21. Signature of Funeral Service Licensee ### M00723 22. Name and Address of F ### M00723 ### M00723 ### M00723	Facility Eli	ne Fun	eral :	Home	
cate be executed with the cate be executed with the cate by social and the cate of the cat	cal ner	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	uch as cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
ath certification	or use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 1 Unknown 9 Unkn				ate of delive	ory Day Year
uires that the de	90	ρχ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did tob		tribute to th	ne cause of death?
VITAL RECOLOS, ician: The law requires t	page 2 should	Completed			24a. Was ar autops perform 1 Yes 2	y	Were auto prior to co- death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of 2 No
	director, page	Be	examiner? Hospital: Other		me 5 Reside		har /Specif	
on o	funeral	ation: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes	2	28d. Describe ho			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location <i>(Sti</i> City or Town	reet and Num , State)	ber or Rura	d Route Number,
the Hospital hin 24 hours the Funeral	pletely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of on Krowledge, death occurred at the time, day of the control of the co	on, death occurre	ed at the time, da	ate and place,	, and due to	the cause(s)
of # of	LOO	2	29b. Signature and title of certifier 29c. License nun			9d. Date sign		
5	Cho	ta	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) When the Complete Completed Cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	& her	ue live	exerce	ke,	th 2006
Re	Sta gistr		APR 2 8 2006					

Please Type or Print in Black Indelible Ink John Edward Lindsay State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0930 hrs **Medical Examiner** John Edward Lindsay, Jr. April 26, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll 952 Deer Park Road Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** oreian Country) Hanover Months Days Min Hours Director 214-42-1860 1 X M 2 62 Yrs March 9, 194 PΛ Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show s 23a or 28a-f show e notified at once. MD Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 952 Deer Park Road 21157 Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14 Race - American Indian, Black must be items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1XX Never Married 2 Married 2 X No Yes <u>-</u> Specify: White Yes 2 No specify. If Yes, Give Year 3 Widowed Divorced Examiner ≥ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Health and Memtal Hygiene
Important: If item 27 is marked other than "nat
injury or other traumatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Machine Operator Lincoln Ladder 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) John E. Lindsay, Sr. Anna Laura Loque Be 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hush Sister 3149 Cardinal Dr., Westminster, MD 21157 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from Stat Deer Park Cemetery 4/26/2006 Westminster, MD Donation 5 Other Specify 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 412 Washington 21157 Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions ner if any, leading to immediate Due to (or as a consequence of) rause Enter Uncerlying Cause (Disease or injury that initiated Exam Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and ian/Medical UNPENDED signed by the attending physician be detached for use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Dav 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? ₫ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been funeral director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) B Hospital: 1 Other: Nursing Hame 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending Yes 2 No · death the Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined within 24 hours a (Specify) 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c License number O.C.M.E. April 27, 2006 and address of person who completed carse of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar's Signature 31. Date filed (Month, Day, Year) 28

Registra

			State Registrar		artment of Health and Natificate of Death	Reg	ne .N2 0 0 6	15228
	Physic	ian	1. Decedent's Name (First, Middle, Last) CHRISTOPHER GENE MIL	ĹER		2. Date of Death Month May	Day Year 8 2006	3. Time of Death 9:02 MM
	/Medi Exami		la. Facility Name (If not institution, give street and numbe 1547 Deerfield Road	r)	4b. City, Town, or Location of Death Darlington		4c. County of Death Harfo	
	Funeral Director		214-82-2434 ¹Ճм 2□F	Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo 10/8/196	9. Birthp Coun Mary	lace (State or Foreign ltry) Land
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	e Man le-f sh	ctor	MD Harford	Darlin				1 ☐ Yes 2 🛣 No
	th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 1547 Deerfield Road		104. Zip Code 21034	10g	Citizen of What Coun	try?
Miller	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or items 23s or 28e-1 show eumatic event, the Maryland Examiner must be notified at	b	11. Marital Status 1 ▼ Never Married 2 ■ Married 3 ■ Widowed 4 ■ Divorced 12. Was Deceder Armed Forces 1 ■ Yes 2 ▼ If Yes, Give Year or Dates	ЙNо	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: W	
	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation hind of work done during most of work DO NOT use retired)	kina 16	b. Kind of Business/Inc	dustry
5	within ane.	mpi	Elementary/Secondary (0-12) College (1-40	(5+)	DO NOT use retired) oment Operator		Constructi	on
7	be filed that Hygie of other there	Be Co	17. Father's Name (First, Middle, Last)	Lqair	18. Mother's Nam	e (First, Middle, Mai	iden Sumame)	<u></u>
Oher	should be and Mental marked o	To E	Blane H. Miller				. Steltz	
9	c, mal y is s t and 2 should f Health and Mer tiem 27 is marke		19a. Informant's Name/Relationship (Type, Print) Cherry Lemly/Sister		ng Address <i>(Street and Number or Rui</i> Box 301, Darlir			Code)
uista	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre-	1 2	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Stat		matory or other place)		c. Location - City or To	
Pris !	it. Pag intment intent: njury		`4 ☐ Donation 5 ☐ Other (Specify) 21. Sign we Funeral Service Licepsee	Dublin Sc	outhern Cem. 5/11 2. Name and Address of Facility	/2006 D	arlington,	MD
, ,	Depart Impo		Leffry P. Live		Harkins Funeral H	ome, Inc.	, Delta, Pi	A 17314
N 03789	Cate be executed /Medical Examiner the buriar-transit the buriar-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as consequence of):	tic Cardiovas			Approximate Interval Between Onset and Death
2	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
	res that the signed by	by	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Š	w requ	Completed				24a. Was an		osy findings available
۵	The lay te has age 2	ошо				autopsy performed	prior to con death?	npletion of cause of
<u>.</u>	sien: ertifica ctor, p	BeC	25. Was case referred to medical examiner?			h (Check only one)		
ž	Physic this or	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	tient 2 ER/Outpatier)
2	ding I th. : After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Day Year) Injury	f 28c. Injury at Work? M 1 \sum Yes 2 \sum No	28d. Describe how i	njury occurred	
Division of Vital Bosords	ol or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not be	njury - At home, farm, str etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural itate)	Route Number,
	Hospite 24 hours Funere etely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner: and manner:	of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier		29c. License number	290	Date signed (Month, L	Day Year)
	^		I Andi-D		12060	5/7	8/01	<u> </u>
	3	-	30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	n do 6	NAID I	110
1	Sta	ate	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	mon si . Hant	vue q	ince of	1078
	Regist		IIIMI I O ZUUD	17 Corele	1			

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene **Lionel Montgomery** Certificate of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Lionel Montgomery Month 1130 hrs Medical Examiner Montgomery April 22, 2006 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Bladensburg Prince George's 4407 56th Ave If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Wash. Months Days Hours Country) D.C Director 02/11/61 579-94-0411 1 X M 2 F 45 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 X No 28a-f show **Bladensburg** MD. Prince Georges death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 23a or 28a-notified at 20710 4407 56th Avenue United States 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. Armed Forces XX must be White etc. Never Married 2 X XMarried Yes No Specify: Black f Yes, Give Year 1 Yes 2 No specify: hours after Divorced à 16a Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ges I and 2 should be filed within 72 I of Health and Mental Hygiene. 27 is marked other than 'matic event, the Medical Baltimore, MD 21215-0036 Dry wall mechanic Home Improvement 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel Montgomery Ora Bell Wrenn 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt: If item 27 i 56th Avenue Bladensburg, MD., 20710 Wanda Montgomery wife 20c. Location - City or Town, State 20b Place of Disposition (Name of cemetery Date 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 Important: I 04/29/06 Harmony Memorial ent Landover, MD. Donation 5 Other Specify 22. Name and Address of Facility Signature of Fune al Service Lidensee 420 H St., N.E. DC. 20002 M01173 B.K. HENRY FUNERAL HOME Wash. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line **Nazcotic intoxication and cocaine and ethanol use** Approximate Interval Physician Between Onset and /Medical Intexication and Death Narcotic Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Ethanol Use Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED 3,27,28a-f,perME,g867,5/3/07 TT burial Records, P.O. Box 68760, The law requires that the death certificate be IF FEMALE 23d. Date of delivery phy: 23c. If ves. outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed tricate has been si 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death 25 Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes After 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural Pending 1 Yes 2 X No the Fnd 4/22/2006 Fnd 11:15 am unk. Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide 4407 56th Ave. Bladensburg, MD (Specify) Found at residence Funeral Homicide 29a Certifier 1 Certifying Physician; Fo,the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b Signature and title of c 29c License numbei 29d. Date signed (Month, Day, Year) O.C.M.E. April 23, 2006 cause of death (Item 23a) 30. Name and address erson Who com Deputy Chief Medical Examiner Mary G. Ripple MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MAY 0 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#2,16a,17,19a,perMD,FH,0855,5/26/06 TT Certificate of Death Reg. No. 2. Date of Death 26 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mary Ε. Minor 28 2006 6:57 рм April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Prince George Hospital Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 78 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number Days 1 □ M 2**X** F 578-30-1571 June 19,1927 DC Usual Residence of Deceden 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₹ No DC Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4339 G Street SE 20019 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🛣 No Specify: by 3 ☐ Widowed 4 XDivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Clerk (Specify only highest grade completed) Fed Govt/Navy Dept Elementary/Secondary (0-12) College (1-4or 5+) Personell 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charle Turner Julia Oueen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eunice Jackson (Niece) 1014 Peconic Place Largo Maryland 20774
ace of Disposition (Name of Date 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem May2,2006 Brentwood, Maryland 21. Signature of Euperal Service Licensee Wash, DC 20011 Tyrone J. Young 719 Kennedy St. NW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failfire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Acute Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Coronary artery disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine Arteriosclerosis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Perpherial Vascular disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 1 🗌 Inpatient 2 XER/Outpatient 3FI DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

g physicien and as the burial-transit The law requires that the death certificate be executed Box 68760. as the ettending | ed by the e Records, P.O. cate has been signed in page 2 should be det Division of Vital or Attending Physician: After within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

Funeral

Director

r than "natural", or items 23s or the Medical Examiner must be

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any light or other traumatic event spage.

Physician

/Medical

Examiner

with the Maryland r 28e-f show

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

No

Medica

ano

2006

29b. Signature and tipe of certifier

(Check only one)

MAY 0 1

m

29c. License number D00 13231

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) April 28,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1160 Varnum Street NE Suite 100 Wash, dc 20017 MD.

32. Registrar's Signature

			For State Registrar	State of M	laryland		artment of H		nd Mental Hy	rgiene Reg. No.	2006	15231
	Physicia		1. Decedent's Name (First, Middle	o, Last)	-	-			2. Date of De Month	Day	Yeer	3. Time of Death
	/Medic		Thomas Glenn Mi				4- 65- T-		April		006	8:30 p M
*	Examin	er	4a. Fecility Name (If not institution		7)		4b. City, Town, or		Death		County of Death Charles	1
	Funeral		6425 Nelson Dri 5. Social Security Number	6. Sex 7. A	ge (In yrs. last	t birthday)	LaPlata If Under 1 Year	If Under 24	Hrs. 8. Date of Bi	rth		iplace (State or Foreign intry)
	Funeral Director		220-42-1998	* ∑ M 2□F	60	Yrs.	Months Days	Hours	Min. (Month, D			yland
	P .		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation			.,		10d. Inside City Limits
	f short	ō		1								1 □ Yes 2√□ No
	26a-	rect	Maryland Char. 10e. Street and Number	ies	Lar	lata	10f. Zip Code			10g. Citiz	en of What Cou	untry?
	h with	Funeral Director	6425 Nelson Dri	ve			20640			U.S	.A,	
	me deat	Iner	11. Maritaf Status	12. Was Decedent		13.	Was Decedent of H	ispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		4. Race - Amer Black, White	
36	s afte	by Fi	1 Never Married 2 X Marr 3 Widowed 4 Divorced	ied 1 ∑Yes 2 ☐ tf Yes, Give Year or Dates:			1 □ Yes 2 XNo	Specify:			Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23e or 28e-f ehow La Madical Exaction on the notified at	edt	15. Decedent			16a. Deced	dent's Usual Occup	ation		16b. Kir	nd of Business/li	ndustry
215	hin 72 an "na Medil	plet	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	(Give life. l	kind of work done of DO NOT use retired	during most o 1)	f working			
21	ed wit	Completed	12			lumb	ing Sheet				. Gover	nment
Maryland	be file d oth	Be	17. Father's Name (First, Middle,					_	Name (First, Middle		Sumame)	
2	hould d Mer marke matic	ဥ	Thomas Wallace 19a. Informant's Name/Relations			19h Mailir		Rosale	e James or Rural Route Numb		Town State Z	in Code)
Ma	od 2 s lith an 27 is r		Sherri L. Milla		6	3425	Nelson Dr	rive T	aPlata, M	-		<i>p</i> 00 00 ,
Je,	s 1 ar		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of matory or other place	(0) 10 - 1	Date		cation - City or T	own, State
Ē	Page nent c ant: If ury or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		old	Durh	am Episco	pal Ch	, 2006 iurch	Iron	sides,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nature!; or Iteme 23a or 28a-f show amortant: in Item 20a or 28a-f show any flury or other traumatic event, its Medical Exaction or other traumatic event, its Medical Exaction or other traumatic event.		21. Signature of Funeral Service		м00668	1	Name and Address Williams 4270 Hawt	Funera	l Home, P Rd., Indi	.A. an He	ead, Md.	20640
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each					rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	" WES	0 L1	TEI	NO M	A				Onsot and Death
	/Medical Examiner		,	Due to (or a	s a consequer	nce of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequar	nca of)						
	cuted nd ransit	Examiner	that initiated events	c								
Ő,	te be executed ysicien and se burial-transit	EX	resulting in death) Last	Due to (or a	s a consequer	nce of):						
68760,	icate be executed physicien and s the burial-transit	dlcal		d								
9 X	thet the death certificate ed by the attending phys detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnanc					2	3d. Date of deli	verv
Box	death a atter d for u	Iclar	in the past 12 months?	4☐Pregnant a	2 Peter de at time of deat]Ectopic pregnancy] Other <i>(specify)</i>	·			Month	Day Year
P.O.	by the	hys	9 Unknown	9□ Unknown								
	res the igned be del	þ	Part II. Other significant condition	ons contributing to death	but not resulting	ng in the u	nderlying cause giv	en in Part I.	1			the cause of death?
ord	w requir been si should I	ted							- 1-1-	Yes 2]No 3∏Pro	bably hknown
l Hecords,	The law requires that the atc has been signed by the paye 2 should be detache	Completed							24a. Wa auto peri 1 ☐ Yes	ormed?	24b. Were aut prior to c death? 1 \(\sum \text{Yes}\)	topsy findings available completion of cause of
/ita	clan: sertific sector,	Be	25. Was case referred to medical examiner?				Tou		f Death Check only	one)		
of	Physic this c	٠ <u>۲</u>	1 Yes 2 10	Hospital: 1 ☐ Inpat		VOutpatier Bb. Time of	oth	4 🗀 (4015)	ing Home 51 Fire			ify)
o	ding h. After funer	tlon	1 Naturat 5 Pendir 2 Necident investig	ng (Month, D	ay Year)	Injury	Wor	yat k? Yes 2∐No		now migury	occurred	
Division of Vital	Atten r deal ector: by the	Ifica	3 Suicide 6 Could	not be 28e. Place of Ir		e, farm, str	reet, factory, office		28f. Location			ral Route Number,
á	s ette el Dire	Certification;	4 Homicide	building, e	etc. (Specify)				City or 10	wn, State)		
	To the Hospital or Attending Physician: The lav within 24 hours efter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifyir (Check only one) Certifyir	ng Physician: To the bes Examiner: On the basis and manner s	of examination	edge, deat n and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
)	To 1 Com	Σ	29b. Signature and title of certifie	E MI	(all	<u>~</u>	D >	f-53),	29d. Date	signed (Month	Day, Year)
3	B 153		30. Name and address of person	DX 17	103	3a) (Type,	Print) Plas	4	MD	20	646	
	Sta Registi		31. Date filed (Month, Day, Year)	2 2006 32. A Jis	strar's Signatur	y 1	Print) PC Jo					

				. For	State of Ma		d / Depa						iene_	0.00	\$ ports	000
				- State Registrar			Ce	rtificat	e of L	Death			eg. No.	UUb		232
	2	Physicia	20	Decedent's Name (First, Middle, Las	_		0.4				2	 Date of Dea Month 	th Day	Year	3. Time o	f Death
		/Medic		GABRIE			MORE		T	.1	(D = ath	5	01	06	054	-7 W
	1.	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death			unty of Death		P)
		<u> </u>		5. Social Security Number 6. Se	HOSPITAL 7. Age	e (In yrs.	last birthday)	BERL If Unde	IN r 1 Year	If Under	24 Hrs. 8	Date of Birth (Month, Day		CESTER 9. Birth	place (State	or Foreign
	v ob	Funeral Director			M 2□F	72	Yrs.	Months	Days	Hours	Min.	(Month, Day 1-23-			intry) STER. I	A.
	100	_		Usual Residence of Decedent											10d. Inside C	
\cap		ehow		10a. State 10b. County	_		y, Town or Lo									2 No
50C		ith the Maryla or 28a-f ehove notified at	Director	PA DELAWARE		EDD	YSTONI		o Code				10a Citizar	of What Cou		X
5		with ti	ă	10e. Street and Number												
3		death with the Maryland me 23a or 28a-f ehow roust be notified at	Funeral	709 EDDYSTONE AV	12. Was Decedent I		.S. 13.		9022 Ident of H	ispanic Ori	igin? (Speci	ify Yes or No- can, etc.)		D STAT Race - Amer	ncan Indian,	
1	(0		표	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1							can, etc.)		Black, White		
9	21215-0036	within 72 hours after dea ene. then "naturei", or iteme ne Madical Exembrer or	þ	3 Widowed 4 Divorced	Year or Dates:			1 LJ TOS	2 <u>11</u> NO	Specify:			Sp	ecity: WH	ITE	
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_	an	d be ental	To Be	ANTONIO MORETTI						RITZ	7 A R I? T'L	FALAS	CA.			
公	Maryland	is 1 and 2 should be of Health and Mental item 27 is marked or other traumatic eve	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mail	ing Addres	s (Street			Route Numbe		own, State, Z	ip Code)	
5		and 2 lealth a m 27 is		KIMBERLY FEELEY/DA	AUGHTER		2910	BURD	EN R	OAD,	PARKS	IDE, PA	A 190	015		
()	Baltimore,	ges 1 a it of Hei iff item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. F	Place of Disponentery, cre	osition (Na	me of		Da			tion - City or	fown, State	
	Ē	permit. Page Department of important: if any injury or once.		4 Donation 5 Other (Specify		LAW	N CRO	FT CE	METE	RY 1	MAY 5	, 2006	LINW	00D, P.	A	
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3/34			1	23a. Part1. Enter the disease or com shock, or heert failure. List only	one cause on each li	d the deat ine.	th. Do not en	iter the mo	de ot dyir	ng, such as	cardiac or	respiratory ar	rest,		Approxima Interval Be Onset and	tween Death
		Priyaician		Immediate Cause (Final disease or condition resulting in death)	7.7		アアソ	ARIL	ERY	DI	SEAS	r.E		E	ERAL ;	FARS
-		/Medical Examiner			Due to (or as	a consec	quence of):									1
_			ĕ	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Due to (or as	a consec	juence of):									
6)		uted d ansit	Examiner	Cause (Disease or injury that initiated events	6											
Q	oʻ	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as	a consec	quence of):									
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	89 x	leath certificate b attending physic i for use as the b	Completed by Physician/Medi	IF FEMALE:	CC Muse sutcame											
0	Box	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	al death 3	□Ectopic p		у			230	 Date of deli Month 	Day	Year
5	0	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	it time or c	1 0 a(i) 5(Cilier (s	роспу/_							
albie	P.0	that the ded by	F.	Part II. Other significant conditions of	contributing to death b	out not res	sulting in the	underlying	cause giv	en in Part	l.	23e. Did to	obacco use	contribute to	the cause of	death?
ರ	ds,	uires l	P	DIABETES A	RELITUS	14	YPEZT	TENS	1014			101	/es 2 □ i	No 3∏Pr	obably 432	Unknown
	Record	aw requir as been si 2 should	jete		•							24a. Was		24b. Were au	topsy finding	s available
	Re	The Iz	E									autor perfo 1 ☐ Yes	rmed?	death?	2□ No	Cause Oi
orethi	Vital	sician: The certificate har rector, page	BeC	25. Was case referred to medical						26. Plac	e of Death	Check only o	10			
9)	of V	ysic lis ce direc	Tof	examiner? 1 Yes 2 No	Hospital: 1 🔲 Inpatie	ent 25	ER/Outpatie	ent 3 🗆 🗅	Oth Oth	ner: 4 🗆 N	ursing Hom	e 5 🗆 Resid	dence 6[Other (Spec	cify)	
0	0 [ding Ph h. After th funeral		27. Manner of Death 1 2 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury a <i>y Year)</i>	28b. Time Injury		28c. Injui Wor	rk?		8d. Describe I	now injury o	occurred		
5	sio	tendi death. tor: A the fu	cati	2 Accident investigatio 3 Suicide 6 Could not b			J	М		Yes 2		8f. Location (S	Steppt and I	Vumbor or D	um l Cloude Ale	mhor
	Division	or At	Certification:	4 Homicide determined		itc. (Speci	ify)	treet, facto	ry, office		20	City or Tox		variiber or Al	II AOULO IVU	inder,
				29a. Certifier 1 ☐ Certifying Pf	nysician: To the best	t of my kn	owledge, dea	ith occurre	d at the ti	me, date a	nd place, ar	nd due to the	cause(s) ar	nd manner as	stated.	
		To the Hospital within 24 hours of To the Funeral completely filled	edicai	(Check only 2 Medical Examone)	miner: On the basis of and manner st		ation and/or i	nvestigatio	n, in my o	opinion, de	ath occurre	d at the time,	date and pl	ace, and due	to the cause	(s)
		To the To the Comp	ž	29b. Signature and title of certifier	11 1 -11	,	4			se number					h, Day, Year)	
				Sorothy C.	Hegworth,	m	2. Di		D	06.29	41		05-	-02-	26	
	C	- 10 . 1		30. Name and address of person who	of pleted cause of	death (Ite	m 23a) (Type	e, Print)	-				_	, .,		
		T 10+1		31. Date filed (Month, Day, Year)	HOLZWO	RTH ,	alure ///	-	263	2 DN	DW -	5T1 5N	10W/1	14 10	12186	3
	4	St Regist	ate trar	MAY 0 2 2	Howard, And Howard Howard And Howard An	111	0 19									

		1	For State Registrar		f Maryland	d / Depa		t of H	ealth a			gienę.	CHILLIES.	15233
			Decedent's Name (First, Middle	Last)						T	2. Date of Dea	ath		3. Time of Death
	Physicia			,,							Month 04	25	2006	19:00 M
	/Medic		MONA MAE MAITHA 4a. Fecility Name (If not institution.	give street and fu	mbar)		4h City	Town or	Location of	of Death			County of Deat	
	Examin	er			inoor)			LISE					WICOMIC	
			ANCHORAGE NURSI 5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under		If Under	24 Hrs.	8. Date of Birt		9. Birt	hplace (State or Foreign
m	Funeral			1 ☐ M 2 □ F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 10-01-		PENN	SYLVANIA
	Director		208-07-0570 Usual Residence of Decedent		- 00						10-01-	1717		
	land		10a. State 10b. County		10c. City	, Town or Lo	ocation	-						10d. Inside City Limits
	Marylan f show	ō	MD WIC	OMICO	SA	LISBUE	RΥ							11√TYes 2 □ No
	the t	Director	10e. Street and Number	OFFICO	D21	LIDDOI	10f. Zip	Code				10g. Citi	zen of What Co	ountry?
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	sath	Funeral	1514 KIVEKSIDE		edent Ever in U.S	S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)	- 1	14. Race - Ame	erican Indian,
	ter di Item	Š	1 Never Married 2 Marri	Armed Fo	orces?		If Yes, spec	ofy Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, Whit	e, etc.
36	rs at	by F	3 ☑ Widowed 4 □ Divorced	If Yes, Gi Year or D	ve A		1 Tes	2∏ No	Specify:				Specify: W	HITE
21215-0036	be tied within 72 hours after death with the Maryland all Hygiene. All Hygiene did the then "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	Completed by	15. Decedent	's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Business	/Industry
<u>.</u>	in 72	olet	(Specify only highes	t grade completed)	4.45.5.\	(Give	kind of wo DO NOT us	rk done d se retired	during mos ()	t of worki	ng			
7	with ene.	E C	Elementary/Secondary (0-12)	College (1-40r 5+)		BEAU	JTIC:	IAN			COS	METOLOG	SY
d	tiled with Hygiene. other ther		17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
an	Mental Merital arked c	o Be	WALTER L. SEHMA	N					ELI	ZABE'	TH EDNI	Ε		
2	2 should be and Menta Is marked eumatic ev	2	19a. Informant's Name/Relationsl			19b. Maili	ng Address	(Street	and Numbe	er or Rura	I Route Numbe	er, City o	r Town, State, J	Zip Code)
Maryland			JAMES DAVIS - S	TEP-SON		910 I	E. GRO	OVE :	STREE	T, D	ELMAR,	DELA	WARE 19	9940
Ġ,	1 ar Hea Hem 3		20a. Method of Disposition	JEE BOIL	20b. PI	ace of Dispe	osition (Nan	ne of	- 1		Date		cation - City or	
<u></u>	nt of nt of t: If if		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	emetery, cre SONS (-	4-29	-2006	SAT.T	SRIIRY	MARYLAND
量	rtan rtan njun		21. Signature of Funeral Service		IAN								HOME,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 li any Injury or other tre	ļ ļ	21. Similardia of Grida Gorvica	2 -	-00.									LAND 21804
			23a. Part1. Enter the disease, or	complications that	caused the death								1 31111111	Approximate
т			shock, or heart failure. List	only one cause on	each line				3,				1	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a			Aso	VD						Syears
п	/Medical Examiner		Tosting in doutry	Due to	(or as a consequ	uence of):								
t.			Sequentially list conditions, if any, leading to immediate	b	(or as a consequ	ience of):				-				
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	200	(or as a consequ	orioe orij.								
	and I-tran	кап	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):							-	
760,	le be executed ysician and e burial-transit				(+- +								- 11	
687	- > a	dlcal		d										
9 x	ertition ding I	/Me	IF FEMALE:	23c If yes or	utcome of pregna	ncv							23d. Date of de	liven
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetal	death 3	□Ectopic p		/				Month Month	Day Year
O.	at the de by the a tached t	Physician/Medl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unki	nant at time of de nown	Balli Ji	Other (st	<i>yeciiy)</i>						
P.O.	The law requires that the death certilical site has been signed by the attending phoage 2 should be detached for use as the	Ph	Part II. Other significant condition	ons contributing to	death but not resi	ulting in the	underlying o	ause div	en in Part I	l.	23e. Did 1	obacco u	use contribute to	o the cause of death?
ŝ	res that signed to be det	by	Part II, Other signmount conduct	one commoding to	304117 241 1101 1301	aning in the	arioony ing c	, a c c c c c c c c c c c c c c c c c c			10	Yes 2	□No 3□P	robably 4 Unknown
of Vital Record	w require been si should I	Completed											T	
ec	law as b	ple									24a. Was	psy	24b. Were a prior to death?	utopsy findings available completion of cause of
<u> </u>		6										ormed? 2 ∰No		s 2 No
ita	Physician: Th r this certiticate ral director, pag	Be (25. Was case referred to medica examiner?							of Deat	h (Check only	one)		
<u>\$</u>	Physic this ce al dire	2	1 ☐ Yes 2 ☑ No			ER/Outpatie	-		4 W N				6 □Other (Spe	ecify)
	ding Ph th. Atter th funeral		27. Manper of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mo	of Injury nth, Day Year)	28b. Time Injury		28c. Injur Wor	rk?		28d. Describe	how inju	ry occurred	
.0	endii sath. or: A he fu	ati	2 ☐ Accident investi	gation			M	1 🗆	Yes 2	No				
Division	or Attendate death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 200. Flat	e of Injury - At ho ding, etc. (Specify	ome, farm, s	treet, factor	y, office		1,100	28f. Location (City or To			lural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely tilled in by the funer	Se								23				
	Hospital 4 hours Funeral tely tilled	cal	29a. Certifier 1 ✓ Certifyin (Check only 2 ☐ Medical	ng Physician: To the Examiner: On the	ne best of my kno basis of examina	wledge, dea tion and/or i	th occurred	at the til	me, date ar opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s)) and manner a d place, and du	s stated. e to the cause(s)
	he H in 24 he F plete	Medical	one)	and ma	nner stated.									
	To the Youthin 2 To the Complete	Σ	29b. Signature and title of certifie	r /			29		se number				te signed (Mon	
	10		mylar Warhum	DR	4SHA 1	VATESA	N	1)0	57350	9			14-28	.2006
L	M		30. Name and address of person	who completed car	use of death (Item	1 23a) (Type	, Print)		m	, ~	ICKA			
	· ·			SICK SI	. SIE.B	5. 5a	USB	URY	, 114)	. 6	004			
8		ate	31. Date filed (Month, Day, Year,	0 2000	use of death (Iten	ture	Cast.	,						
14.00	Regist	rar	APR 2	O ZUUD	BEING I	es. In								

06-02841 Alfred Massev. Sr.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

neu Massey,			ertificate of Death	Reg.	No 200	6 1523
Physici ledical Exam	an/	1. Decedent's Name (First, Middle,Last) ALFRED MASSEY, SR.		2. Date of Death Month Da April 27, 200	ay Year	3 Time of Death - 0001 hrs
edical Exam	IIICI	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		4c. County of Death	
		Prince George's Hospital Center	PG Hospital Cente		Prince George	
Funeral Director			Months Days Hours	er 24Hrs. 8. Date of Birth() Min.	Foreig	n
		388-40-0453 1 M 2 F Usual Residence of Decedent	66 Yrs	SEPT.16	5, 1939°°°	untry) WASH. D
v any			ity, Town or Location			10d Inside City Limits
Aaryland 28a-f show 1 at once.	tor	D · C · WA	ASHINGTON 10f, Zip Code	Lion	Citizen of What Cour	1 X Yes 2 No
ne Mar or 28a	Director	630 EMERSON ST., N.E.	20017	Tog.	U.S.A.	·
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiens and unit. If item 27 is marked other than "natural", or items 23a or 28a-f she mir If item 20 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		11 Marital Status 12 Was Decedent Ever in	ILS 13 Was Decedent of Hispanic Ori		14. Race - Americ	can Indian, Black,
r death or iter must	Funeral	1 Never Married 2 Married Armed Forces? Yes 2 No.	If Yes, specify Cuban, Mexican		White, etc.	N CIV
ırs afte ural",	ē.	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify. 16a. Decedent's Usual Occupation (Give		Specify: BLA	
72 hou ra "nat	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT	use retired)		
5-0036 Iled within 72 Hygiene. I other than 'the Medical	Comple	11th 17. Father's Name (First, Middle, Last)	VENDOR 18 Motho	r's Name (First, Middle, Maid	SALES	
215- be filed ntal Hyg rrked otl	Be C	ALFRED THOMAS		ONNIE MASSE		
s, MD 21215-003 and 2 should be filed withi teath and Mental Hygiene. tem 27 is marked other it traumatic event, the Med	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nur			
, MD ind 2 sho salth and em 27 is		ARNOLD MASSEY/ SON 20a. Method of Disposition 20	8723 CONTEE RD. b. Place of Disposition (Name of cemetery,	•	Oc. Location - City or	
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:		1 N Burial 2 Cremation 3 Removal from State	crematory or other place) C. ZION CEMETERY		BALTIMOF	
altim nit Pe partmet portan		4 Donation 5 Other Specify. 21. Jign-flure of Funeral Servic Licenshe	22. Name and Address of Facilit		APITOL MO	
in in Degra	l.	Sparon Johnson Ja	lly 1425 MARYLANI	· ·		
Physician /Medical		23a. Part I. Enter the disease or complications that caused he defailure. List only on cause on each line	(/ '	cardiac or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final dist ase or condition resulting in death) a. Mixed Alcohol and Due to (or as a consequence)	and cocaine intoxication e of):			Death
	L	Sequentially list conditions, b.				
	miner	if any, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated	e of):			
ed	ו מס	events resulting in death) Last Due to (or as a consequence	e of):			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit	Medical	d. X UNPENDED AMENDED item#2	3a,27,28a-f,perME,g855,5/1	17/06 TT		
760, cate be physic	/Med	IF FEMALE: 23c. If yes, outcome of pi			23d. Date of delivery	
certifi reertifi ending use as	ician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of	2 Fetal death 3 Ectopi f death 5 Other (Specify)	c pregnancy	Month E	Day Year
cords, P.O. Box 68: law requires that the death certifi has been signed by the attending 2.2 should be detached for use as:	Physic	1 Yes 2X No 9 Unknown				
P.O. es that the gened by be detach	by	Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause given in P		cco use contribute to 2 No 3 Prob	
ds, equire: een sig	ompleted			24a. Was an		topsy findings available
COT te law 1 te has b	du		· · -	autopsy performe	d? death?	completion of cause of
ital Recicion: The scertificate rector, page	ပြိ	25. Was case referred to medical	26 Place of Death			2 10
Division of Vital Records, tal or Attending Physician: The law requirar are after death and a Directors. After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should	10 B	162 7 100	✓ ER/Outpatient 3 DOA Other		sidence 6 Other	-
nn of anding Ph	io ie ie	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Fnd 4/26/200	28b. Time of Injury 28c. Injury at Wor Find 11:08 PM 1 Yes 2X	7	vinjury occurred	
/iSior r Attencter death	ertificati	2 Accident Investigation	At home, farm, street, factory, office building, e	Carat.	eet and Number or Ru	ral Route Number, City
Divipital or ours after teral Diripited in filled in	Certi	4 Homicide determined (Specify) Found	: in car	Benning Re	d. Capitol H	eights. MD
Division To the Hospital or Attento within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my know one) Wedical Examiner: On the basis of examination				
To t with To t	Med	and manner stated. 29b. Signature and tyle of certifier	29c. License number		9d Date signed (Moi	
		XH/1AN/M	O.C.M.E.	A	April 27, 2006	
		30. Name and address of person who completed cause of death (I	· ·			
		Susan Hogan MD. Assistant Medical Examir 31. Date filed (Month, Day, Year) 32. Registrar's Signary		MD 21201		
Regi		***** A D AAAC ### - #	field			

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>			ealth and Death	d Me	ntal H		ne _{No.} 2 (106	15235
	Physici		Decedent's Name (First, Middle, Lass SARAH	MARCI	īc.					j	Date of D Month APRIL		Day 2006	Year	3. Time of Death
ž	/Medic Examin		4a. Facility Name (If not institution, give				4b. City	Town, or	Location of D			2,,		y of Death	1.00
			HOLY CROSS HOSPITAL					ER SPI	RING				MONTGO		
	Funeral Director		5. Social Security Number 6. S 036 - 09 - 1463	ex □M 2∐ÅF	7. Age (In yrs	i. last birthday) o Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	Ain.	. Date of E				lace (State or Foreign try) ISLAND
		}	Usual Residence of Decedent		0	0				IM	ARCH 1	.4, 1	.910	KHODE	ISLAND
	how	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits
	8a-f	Director	MARYLAND MONTGOMERY		CHE	VY CHASE						1			1 ☐ Yes 2 🖺 No
	with ti	D	10e. Street and Number					o Code				10g.		What Coun	itry?
	ns 23	Funeral	8411 SPENCER COURT 11. Marital Status	12. Was Dec	cedent Ever in I	U.S. 13. \		0815 dent of Hi	spanic Origin?	? (Specif	v Yes or f	No-	U.S.	A. ce - Americ	an Indian.
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f ehow other then "natural", or items 23a or 28a-f ehow event. The Medical Examinar must be notified at	by Fun	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed F	orces? 2 ሺ No ive		fYes, spe 1 ☐ Yes		spanic Origin? n, Mexican, Pi Specify:	uèrto Rio	can, etc.)			ck, White,	etc.
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21215	thin 7.	Completed	(Specify only highest gra) (1-4or 5+)	life. I	RING OF WI DO NOT L	ork done d ise retired	luring most of)	working					
7	ygien ygien rer th	Co	1.2			ADMINIS	TRATI	VE ASS						GOVERN	MENT
_	m - 0 5	Be	17. Father's Name (First, Middle, Last)						18. Mother's I	Name (/	First, Midd	le, Maio			
Ĕ	hould d Mer mark matic	2	ZELIG 19a. Informant's Name/Relationship (MIRMAN		19h Mailin	n Addres		LILLIAN and Number or	r Rural F	Route Nur	her Ci	RICH		Code
<u>8</u>	nd 2 s lith an 27 is r treu		ELLEN R. MARCUS/DAUGH	•			•	·					•		IA 22206
ē,	t Head the Cothern		20a. Method of Disposition		20b.	Place of Dispo				Dat		-		- City or To	
altimore,	Page nnt: If		1 🖾 Burial 2 □ Cremation 3 🖾 4 □ Donation 5 □ Other (Specify		Jiaio	NG DAVID			!	/30/2	006	FAL	LS CHU	JRCH V	IRGINIA
	permit. Pages 1 end 2 should by Department of Health and Menta Important: If tem 27 is marked any injury or other treumatic of once		21. Signature of Funeral Service Licer	see		22	. Name a	nd Addres	s of Facility FUNERAL	·					
<u> </u>	205 2 2	- 2	* Umarda	ndeu	rg		800 N	EW HAM	PSHIRE A	AVENU.	E, SIL	VER	SPRING	, MARY	LAND 20904
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on	catesed the dea each line.	ath. Do not ent	er the mo	de of dying	g, such as care	diac or r	espiratory	arrest,			Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ч	TATIC CAI					_					WEEKS
	Examiner		1		(or as a conse									24	- ministra
		er	Sequentially list conditions, if any, leading to immediate	D	AN CANCEI										HEEKS
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Р. О	0 0 0	hysi	1 Yes 2 No 9 Unknown	9□ Unki											
	The law requires that the ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions of	ontributing to	death but not re	sulting in the u	nderlying	cause give	n in Part I.		23e. Dio	tobaco	co use con	tribute to th	e cause of death?
ğ	w require been sig should b	ted t	URINARY TRACT INFECTI	ON						_	1[] Yes	2 🗌 No	3 Proba	ably 4 ⊠Unknown
ပ္မ	as be	Completed	DEHYDRATION								24a. We	is an	24b.	Were autor	osy findings available inpletion of cause of
<u>~</u>		Con									per 1 ☐ Yes	formed 2 🛭	? No	death?	2 No
<u>₹</u>	certifi	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of I						
ō	Phys	٦.	1 Yes 2 No	14	Inpatient 2 [of Injury oth, Day Year)	ER/Outpatien 28b. Time of		28c. Injury Work	4 Nursin				6 Oth		"
o	nding F th. :: After e funer.	attor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		nth, Day Year)	Injury	М		?. ∕es 2 □ No				. ,		
Division of Vital Records,	ial or Attending Physician: s after death. al Director: After this certifica ed in by the funeral director.	Certification:	3 Suicide 6 Could not b	289. Plac	e of Injury - At I	home, farm, str	eet, factor	y, office		281	Location City or T	(Street	and Numi	ber or Rura	l Route Number,
	ital o														
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medical	29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Exam	niner: On the l	e best of my kr basis of examin nner stated.	nowledge, death nation and/or inv	occurred vestigation	at the tim	e, date and pl pinion, death o	lace, and occurred	d due to th at the time	e cause e, date	e(s) and m and place,	anner as stand due to	ated. the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier				29	c. License	number			29d.	Date signe	ed (Month, I	Day, Year)
}	15		M externity				1	32332				APR	IL 27,	2006	
			30. Name and address of person who		· ·		,		approa	\(1 = 25=	-	0000			
	Sta	to	S.K. GUPTA, M.D., 980 31. Date filed (Month, Day, Year)		A AVENUE,	aturo			SPRING,	MARYI	AND 2	0902			
	Registr			0000	delives	Re d	mark	,							

			For State Registrar	State of Mar		artment of H			iene •g. No. 200	6 15236
	Physici	an	1. Decedent's Name (First, Middle, Last) John Wesley	Moor				2. Date of Dea Month	Day Yea	3. Time of Death
The state of the s	/Medic Examin		4a. Facility Name (If not institution, give st		timore	4b. City, Town, or	Location of Deat	h May	4c. County of De	ath 8.00 p
	Funeral Director		5. Social Security Number (6. Sex 217–46–1467	7. Age (M 2□F 5(n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9.8 1949 Mar	irthplace (State or Foreign Country) Cyland
	Maryland	lor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford	1	Oc. City, Town or Lo					10d. Inside City Limits
	with the	Directo	10e. Street and Number			10f. Zip Code	204	1	0g. Citizen of What	Country?
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinar must be notified at	by Funerai	103 S. Law Street 11. Marital Status 1 Never Married 2014 Married 3 Widowed 4 Divorced	2. Was Decedent Even Armed Forces? 1 ☐ Yes 2/1 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🕦 No	001 ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Thite
Maryland 21215-0036	within 72 hour ene. than "natural	Completed t	(Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done on DO NOT use retired affic Man	during most of wo ()	rking	16b. Kind of Busines	
land 2	be filed Ital Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) Harry Moor		110	allic Mail		me (First, Middle, i	Maiden Sumame)	•
-	and 2 should laith and Men 27 is marke er traumatic		19a. Informant's Name/Relationship (Typ Linda Moor (wife)	9, Print)		ng Address (Street a			; City or Town, State	. Zip Code)
Baltimore	Pages 1 end ment of Healt ant: If Item 2 lury or other		20a. Method of Disposition X⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		BelAir Me	matory or other place morial Ga	rdens 5/	12/06	20c.Location-City o BelAir, Ma	ryland
Balt	permit. Page Department important: If any injury or		21. Signature of Funeral Service Licensed 23a. Part 1. Enter the disease, or complice	I (Mgles)	Hel A	berdeen,	Maryland	21001-3	399	l Home, P.A.
	death certificate be executed Exam Medical Figure 2 A strengting by sicien and of for use as the burial-transit A for use as the burial-transit	dicai Examiner	shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a c	consequence of):	sheric		with he	eviation	Approximate Interval Between Onset and Death a days Loyears To years
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
Ω.	w requires thet the been signed by th should be deteche	þ	Part II. Other significant conditions cont	nbuting to death but r	not resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
of Vital Records,	The law ete has b page 2 si	Completed	5 Y 1917					24a. Was a autops perform	y prior to	autopsy findings available completion of cause of es 2 1 No
	ding Physician: h. After this certifice funeral director, p	tlon: To Be	27. Manner of Death 1 Natural 5 Pending	spital: 1 X Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier	f 28c. Injun Work	ar: 4 ☐ Nursing H	1	ence 6 Other (Sp ow injury occurred	ecify)
Division	al or Attending s efter death. el Director: After ed in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (· At home, farm, st Specify)			28f. Location (St City or Town	reet and Number or i	Rural Route Number,
	To the Hospital or Al within 24 hours effer of To the Funerel Direc completely filled in by	edicai	29a. Certifier 1 Certifying Physi (Check only one) 1 Medical Examination	cian: To the best of o er: On the basis of en and manner state	camination and/or in	vestigation, in my o	oinion, death occu	urred at the time, d	ate and place, and di	ue to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	bol	t MD	29c. Licenso			9d. Date signed (Moi	/ ' '
_	3	2	30. Name and diess of person who con	Rhe	inbolt	Print) Sin	ai Hy	stal of	5/8/ Balliv	nore
	Sta Reg istr		31. Date filed (Mortin, Day, Year) MAY 1 5 200	32 degistrar's	Signature	antis	/-/	,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0530M Belmont Mayhew Vernon /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner egany sacred Heart Hospital brookerland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1∭ M 2□ F Yrs. 216-22-7214 Director 06/03/1926 Maryland Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ehow r then "natural", or items 23a or 28e-f ehov The Madical Examinan must be notified at 1 ☑ Yes 2 ☐ No **Funeral Director** MD Cumberland Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 317 Footer Place USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∑Yes 2 □ No 1944 If Yes, Give
Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Tire and Rubber 11 permit. Pages 1 and 2 should be file.
Department of Heelih and Mental Hyg important: if Item 27 le marked other any injury or other traumestimans. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilma Franklin Mayhew Powel1 Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Footer Place, Cumberland, MD Maretta L. Mayhew / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1)XBurial 2 Cremation 3 Removal from State Sunset Memorial Park 04/28/2006 Cumberland, MD 4 □Donation 5 □Other (Specify) 21. Signature of Foneral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart tailure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner tenis xlero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner physicien and s the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical use as the igned by the attending be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes Division of Vital atter deeth.

Director: After this certifice To the Hospitel or Attending Phyeiclen: within 24 hours atter deeth.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 1- Naturat 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyler stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 21,2006 w 10 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Cumberland MO 21502 VIKramadit oona 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 6 2006

06-02763

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Jennifer Morelock Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1700 hrs Medical Examiner Jennifer Lynn Morelock April 23, 2006 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death University Hospital-Shock Trauma **Baltimore** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex If Under 1 Year ⁴ Funeral 7. Age (In vrs. last birthday) Months Days Hours Min Director 217-13-9354 Country) 1 M 2 XF Feb 09 1981 25 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits M 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. New Windsor MD Carroll nours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Numbe 21776 USA 1526 Old New Windsor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2 X No. Yes Specify: White If Yes, Give Year 1 Yes 2 X No specify Widowed Divorced Examiner "natural". \$ Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 intent of Health and Mental Hygiene ant: If item 27 is marked other than " event, the Medical Baltimore, MD 21215-0036 Student Cosmetology 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Deborah Schwartz Be Glenn Morelock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Luber/Mother 1526 Old New Windsor Road New Windsor, MD 21776 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date crematory or other place) tant: If i 1 XBurial 2 Cremation 3 Removal from State Meadowridge Memorial Fk 4/27/2006 Elkridge, MD Donation 5 Other Specify. 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. nature of Funeral Service Licenses 21157 Westminster 412 Washington Road Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wounds (2) to Neck and Chest Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and sician/Medical uttending physician or use as the burial -UNPENDED AMENDED requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 2 🗸 Fetal death 3 Ectopic pregnancy Live birth Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Apr 23, 2006 1 Yes 2 No 9 Unknown q Unknown the Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ ⋧ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an certificate has been 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 V Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one To the Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 Other4 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other After this 1 Yes ဂ္ 28a. Date of Injury (Month, Day Year) Apr 23, 2006 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject shot Natural 1211 hrs 5 Pending 1 Yes 2 ✔ No death Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2500 block of Arunah Avenue, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) MJ April 24, 2006 O.C.M.E. 3 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signatu Month, Day Year) APR 2 8 31. Date filed (Month, State 2006

Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:30 M MACK 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)

Months Days Hours Min. Jan. 26, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 E 098-12-6441 Months 83 Yrs. Director 1923 New Jersey Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28a-f show traumatic syant, the Modical Examinar must be notified at Maryland Anne Arundel Annapolis 1 X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 A Spa Creek Landing 21403 U.S.A. within 72 hours after death Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2000 Specify: þ Specify White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic avant, Ite Media 2009. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oliver McCroskery Dell Vogel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Britt/daughter 4 A Spa Creek Landing Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Crematory 4/27/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature - Poli eral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** /Medical Due to (or as a consequence of): Examiner carcino motoris intrapulmono Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) been signed by the attending physicien and should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autoosy performed spital or Attending Physician: Thours effer death.
uneral Director: Affer this certificate filled in by the funeral director, pt 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 2Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPOLIS MOZIYON 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

			State of Maryland / Department of			_	
			1 - State Registrar Certificate			_/HH	15240
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		JEAN SHEPARD MILLER				2:10 P. M
J	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Total	wn, or Location of Death	Mental Hygiene Reg. No. 2	th	
			ANNE ARUNDEL MEDICAL CENTER ANNAP				
п	Funeral			Year If Under 24 Hrs. Days Hours Min.	(Month, Day, 1	(ear) 9. Birt	hplace (State or Foreign buntry)
	Director		218-66-8515 51 Trs. Usual Residence of Decedent		APRIL 8,	1900 WAS	HINGION, D.C
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-f s	ctor	MARYLAND ANNE ARUNDEL ODENTON				1 ☐ Yes 2 X No
	ith th	Director	10e. Street and Number 10f. Zip Co				ountry?
	s 23a	ra		1113			siana laulian
	item item	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No 13. Was Decedent If Yes, specify	Cuban, Mexican, Puert	to Rican, etc.)		
336	Jrs af	by F	If Yes, Give 1 Yes 2 V Year or Dates:	No Specify:		Specify: [π
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show Its M. dical Ex., nihar i, ust b., notified a	Completed by Funeral	15. Decedent's Education 16a. Decedent's Usual C (Specify only highest grade completed) (Give kind of work of	Occupation	rking 10	6b. Kind of Business/	Industry
21	thin 7	npie	Elementary/Secondary (0-12) Coilege (1-4or 5+)	done during most of wor retired)	, Alling		
	filed wi Hygien other th	Col	3 RESPIRATORY				E
and	be fi	Be	17. Father's Name (First, Middle, Last) KENNETH L. MCCOY			,	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M.	To					7ic Code)
Ma	S as						
ē,	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Disposition (Name				Town, State
Ë	Pages nent of l int: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) HUNTT CREMATORY		6/2006 V	VALDORF, M	ARYLAND
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.		21. Signature of Funeral Service Licensee 22. Name and A	Address of Facility RC	OBERT E. I	EVANS FUNE	RAL HOME
<u> </u>	89 = 9						20717
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode o shock, or heart failure. List only one cause on each line.	f dying, such as cardiac	c or respiratory arres	it,	Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death) a. A ening, tis				7000
	/Medical Examiner		Due to (or as a consequence of):				>10-1
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury				100
	uted d ansit	min	cause, Enter Underlying Cause (Disease or injury that initiated events c.				
ó	ate be executed hysician and the burial-transit	cai Examiner	resulting in death) Last Due to (or as a consequence of):				
3760,	The law requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit		d				
x 68	that the death certifical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE:				
Вох	ath c attenc for us	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregr				•
P.O.	the de	ysic	1 Yes 2 Unknown 9 Unknown	9)			
	that ned by deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	w requires that s been signed E should be deta	q pe			1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
000	aw re is bee 2 sho	piet					
m.		Completed			performe	d? death?	
Vital	ıysician: The law iis certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?		ath (Check only one)	1	
of \	> . 0	To	1 Yes 2 No Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA				cify)
n C	ding Phys	lon	1 Natural 5 ☐ Pending (Month, Day Year) Injury	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe now	injury occurred	
Division	Attending or death. ector: After by the fune	ficat	3 Suicide 6 Could not be		28f. Location (Stre	et and Number or Ru	ıral Route Number,
Div	after after Directory	Certification;	4 Homicide building, etc. (Specify)		City or Town,	State)	·
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Affer th completely filled in by the funeral		29a. Certifier (Check only (C	the time, date and place	a, and due to the cau	se(s) and manner as	stated.
	he Ho in 24 he Fu pletel	Medical	one) and manner stated.				
	To T To 1	Z		icense number		d. Date signed (Montl ソーフレーク	
			for 1 gelleson my	24801		1 27-0	9
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	24804 + 1 MC	Ann	opolis Mi	d
	Sta	ite	31. Date filed (Month, Day, Year) 39 Registrar's Signature				
	Regist		APR 2 6 2006				

		í	For State Registrar	State of Ma	aryland		artment of F tificate of		d Mental H	ygiene Reg. No	- 7 11 11 11	1524
			1. Decedent's Name (First, Middle, La	ıst)					2. Date of D			3. Time of Death
	Physicia /Medic		Annetta E. Mi	lls					April		2006	7:10 A. ^M
A STATE OF THE PARTY OF THE PAR	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, o		Death	40	County of Death	_
			Lorien @ Rivers: 5. Social Security Number 6.		/In ure le	ast birthday)	Belca:		Hrs. 8. Date of E	Righ	Harford	place (State or Foreign
Т	Funeral Director			1 ☐ M 2 □ XF	83	Yrs.	Months Days		Min. 3/11/	1923	Mary	vland
			Usual Residence of Decedent						1 + 1 + 1			
	urylan show	Ļ	MD Harfor	ad		, Town or Lo	cation					10d. Inside City Limits Mayes 2 □ No
	Ba-f	ecto		-u	ADE	rdeen	1404 7:- 0-4-			10- 0	id () A // A / O	
	a or 2	Funeral Director	10e. Street and Number 328 Roberts Way				10f. Zip Code	21001		log. Ci	itizen of What Cou	ntry r
	na 23	era	11. Marital Status	12. Was Decedent I	Ever in U.S		Vas Decedent of H	lispanic Origin	? (Specify Yes or I	No-	14. Race - Ameri	
21215-0036	uid be filed within 72 hours after death with the Maryland fental Hygiene. Ked other than "natural", or itema 23a or 28a-f show tite event, the Medical Examiner hunt be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	10	-	fYes, specify Cub □ Yes 2 🛛 No	an, Mexican, P Specify:	uerto Rican, etc.)		Black, White,	
O	72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Deced	lent's Usual Occup	ation during most of	f working	16b. F	Kind of Business/Ir	dustry
2	within 72 ene. than "nai he Medic	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done OO NOT use retire	d)		_		
	filed w Hygier other th		12 17. Father's Name (First, Middle, Las	0		Homen	aker	18 Mother's	Name (First, Midd		n home	
Maryland	d be t) Be	Joseph Krall	.,					ine Hille		,	
<u> </u>	nd 2 should be ith and Mental it and Mental it is marked o	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street		or Rural Route Num			o Code)
	te tre		Robert M. Mills	(Son)		125	East Noc	k Lane	Camden	, DE	19934	
ě.	ss 1 and of Healt item 2 r other		20a. Method of Disposition	7D	20b. Pl	ace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City or T	own, State
Ĕ	Peges ment of ant: If it ury or o	U	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		R.	A. Fer	ris & Co	4,	/25/06	West	t Cheste	c, PA
Baltimore,	permit. Peges Department of I Important: If it eny injury or o		21. Signature of Funeral Service Lice	ellma	n	²² 1 A	Name and Address arring—C berdeen,	ss of Facility argo Fu Marvla	uneral Ho and 2100	me, 1 1-33	P.A. 99	
H			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death							Approximate Interval Between
j.	Physician		Immediate Cause (Finat disease or condition	Ad	Van	cel	Alzh	e (m 01	is De		n+10	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):	-/ ">"	~ · // E /	77	7716	71, 101	
		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequ	ence of):						
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events			_						
o Î	en an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):						
8760,	cate be executed physicien and the burial-transit	dical		d								_
9		a)	IF FEMALE:	202 16	_6							
Box	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)	y			23d. Oate of deliv Month	ery Day Year
o.	9 9 9	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	tillie or de	saiii 5_	Other (specify) _					
J.	law requires that the es been signed by th 2 should be detache	by Pr	Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the ur	nderlying cause giv	en in Part I.	23e. Dio	d tobacco	use contribute to	he cause of death?
ğ	w require been sig should b		Failure	to the	arit	10			10	Yes 2	2 No 3 □ Pro	bably 4 🗀 Unknown
Vital Records,	law re as bee 2 sho	Completed	'Kenal	Failure	2				24a. Wt	as an topsy	24b. Were auto	opsy findings available ompletion of cause of
ř	The ate h page	Som	(40. (c)	, , , , , , , , , , , , , , , , , , , ,					pei 1□ Yes	rformed?	death?	
Ita	sicion: The certificate rector, pag	Be (25. Was case referred to medical examiner?	17					Death (Check only	y one)		
5	Physi this c	7°	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatien 28b. Time of		4 Nursi	ng Home 5 ☐ Re			(y)
o	or Attending Physicien: uter death. Director: Atter this certifici	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day	Year)	Injury	28c. Injui Woo	yat rk? Yes 2∐No		e now mije	лу оссилеа	
Division of	il or Attendi after death Director: A	flca	3 ☐ Suicide 6 ☐ Could not	28e. Place of Inju	ury - At ho	me, farm, str			28f. Location		nd Number or Rur	al Route Number,
á	s afte	Sert	4 ☐ Homicide determined	building, etc.	c. (Specity	")			City or I	own, Stat	(e)	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best miner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at the til restigation, in my o	me, date and p opinion, death	place, and due to the control occurred at the time	ne cause(s e, date an	s) and manner as s nd place, and due t	stated. o the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Month,	Day, Year)
•				1m	2		L VI	558	3	Ac	nil 21	e 2006
	7		30. Name and address of person who			-	Print)		1 1	- 1	45	
	<i>←</i>	10	31. Date filed (Month, Day, Year)	_azath	W ar's Signat	ture (o Law	Stree	et, Abe	rde	en, mi) 2100]
	Sta Registr		31. Date filed (Month, Day, Year) APR 27	2000		# 4	hour					

State of Maryland / Department of Health and Mental Hygiene? 15242 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** RAQUEL MEJIA 2:55 P M April 23 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hospice-Casey House Montgomery Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 🖾 F 85 215.27.0588 1921 Guatemala Director 16, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar ariment of Heelth and Mental Hygiene. ortant: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow ortant: If Item 27 is marked other then "hatural", or other treumatic event, it a Medical End. it are must be neutified at all plury or other treumatics. 1X Yes 2 □ No Directo Gaithersburg Montgomery Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Guatemala 92 Anna Court 20877 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Guatemalán Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Food Services Deli Chef 6th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Maria Mejia ပ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma Vasquez/Daughter 92 Anna Court, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Ceme. 04/29/2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Idiopathic Fibrosis Alveolitis Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Que to for sels consequence of The law requires that the death certificate be executed attending physicien end for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 🖾 No O 9 Unknown 9 Unknown ۵. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy performed? certificete 1 ☐ Yes 2 No 1 Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) Hospice 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Division 5 Pending investigation 1 ANatural after death.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) ţ 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) MI April 24, 2006 D-35635 30. Name and addless of erson who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Joseph Kaplan, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Connie Marie MARTIN 4:30 AM APR.(L 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 23,1930 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 28 F Yrs. Maryland 75 220-26-5166 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Example rount to inclified at 1 ☐ Yes 2X No Smithsburg Director Washington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22108 Holiday Drive 21783 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. ent: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) office worker sandblasting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd C. Main Helen Wade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lawrence Martin - husband 22108 Holiday Dr., Smithsburg, Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 5/3/06 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee -415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 18 mont **Physician** Adenocarcino ma Unknow disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 No 1 Tes . To the Hospital or Attending Physician: within 24 hours after death. ←∓o the Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-20.06 041667 nulaine MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Compres Hoseratura MO McCo, 11110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAYO

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State	of Marylar	•	artmen rtificat			and M		giene Reg. No.	006	15244	
	Physicia	an	1. Decedent's Name (First, Middle		*						2. Date of De Month	Day	Year	3. Time of Death	
	/Medic	al	Donald Needy 4a. Facility Name (If not institution		number)		4h City	Town or	Location o	of Death	April	28 4c Cou	2006 nty of Death	7:05 A [™]	_
•	Examin	er	Williamsport	M1					amspo				•	n County	
	Funeral		Social Security Number	6. Sex M 2 ☐ F	7. Age (In yrs.			1 Year_ Days			8. Date of Bird (Month, Da	th	9. Birth	place (State or Foreign	_
	Director		217-16-2614	M_JM 2UF	8	4 Yrs.			,,,,,,,		Jan 14	1922		rýland	_
	ow is		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits	_
	a-f sh	ctor	Maryland Was	hington		Hage	ersto	wn						1 ☐ Yes 🎇 No	
:	3a or 28	il Director	10e. Street and Number 106 N. Edge	wood Dri	ve		10f. Zip		1740			10g. Citizen U.	of What Cou	intry?	
9	permit. Pages 1 and 2 should be lited within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23s or 28s-f show any injury or other treumatic avent, the Medical Examinar must be notified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 🛣 Marr 3 □ Widowed 4 □ Divorced	Armed 1 X Yes If Yes, (. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 4-13-1 1 ☐ Yes 2 ☒ No 4-13-1 1 ☐ Yes 2 ☒ No Year or Dates: 5 10 1046				spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or No Rican, etc.)	- 14. F E Spe	lace - Ameri lack, White cify: Wh		
3	atura eal E		15. Deceden	t's Education		19–1946 16a. Dece	dent's Usu	al Occupa	ition			16b. Kind of	Business/Ir		-
7	Madi	Completed	(Specify only highes Elementary/Secondary (0-12)		d) e (1-4or 5+)	(Give	kind of wo DO NOT u	rk done a se retired,	luring most)	t of workii	ng				
7	ygien ygien yer th	Con		1		<u> </u>	Serv:	ice M	lanage		451			e Dealershi	p
	ntal H ed ott	Be	17. Father's Name (First, Middle,	,							(First, Middle, de Need				
3	2 should be lited within and Mental Hygiene. Is marked other than eumatic avent, the Mental Hygiene.	To	Eugene D. Myers 19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a			I Route Number			o Code)	_
-	end 2 ealth a n 27 is		Wilma Fern My	ers (wif	fe)	106	5 N. I	Edgev	vood I	Drive	Hager	stown 1	Maryla	and 21740	
. ע	of He of He if item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal fro	1	Place of Dispo cemetery, crea	osition (Nai matory or c	ne of ther place			ate	20c. Locatio	n - City or T	own, State	
	ment of htant: If its		4 □ Donation 5 □ Other (S	pecify)	Re	st Have				_	1 2006			n Maryland	
0	Departr Importa any inju		21. Signature of Funeral Service	Al Zin										ral Home land 21742	
		1	· 23a. Part1. Enter the disease, of shock, or hear failure. List	complications that	t caused the dea									Approximate Interval Between	_
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a P	neumo									Onset and Death 3 days	
ı	Examiner			b di	to (or as a consec	quence of):								Vents	
	sit BC	lner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	to for as a consei	runerna of):									
'n.	icate be executed physicien and sthe burial-transit	al Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):												
00	physics the	edic		d											
. DOX	To the Hospital or Attending Physicien: The law requires that the death certific in thin 24 hours effect death. To the Funeral Director: After this certificate has been signed by the ettending ploompletely filled in by the funeral director, page 2 should be detached for use as it completely filled in by the funeral director, page 2 should be detached for use as it.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregn e birth 2 Peta egnant at time of a known	al death 3	⊒Ectopic pi ⊒ Other (sc						Date of deliv Month	ery Day Year	
, ()	res thet signed by	þ	Part II. Other significant condition		failuce		inderlying o	ause give	n in Part I.			obacco use co	/	the cause of death?	
	v requ	letec	cerebrovascu					- 7 - 2 - 2 - 2			24a. Was			opsy findings available	
בי בי	i: The lay	Completed	cerebrovasa	ijar ai	13 66(2)						autop		prior to co death?	ompletion of cause of 2 ☐ No	_
= :	certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		7500		Othe			(Check only o				7
5 1	a Phy er this eral d		27. Manner of Death	28a. Da	te of Injury	28b. Time o		8c. Injury Work	at 1127Nu		ne 5 Resid			(y)	-
5	ath. or: Aft	atio	1 A Matural 5 ☐ Pendin 2 ☐ Accident investig	gation	onth, Day Year)	Injury	М		Yes 2□1	No					
	To the thouse the attending Physicien: The law within 24 hours effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could i	ined 208. Pid	ace of Injury - At h ilding, etc. (Speci	nome, farm, str ify)	reet, factor	, office		2	8f. Location (S City or Tox	Street and Nu vn, State)	mber or Rur	al Route Number,	
	Hospit 24 hour Funers etely fills	edical (29a. Certifier 1 Cartifyin (Check only one) 2 Medical	y Physician: To t Examiner: On the and ma	the best of my kn a basis of examina anner stated.	owledge deat ation and/or in	h oncurred vestigation	at the tim , in my op	date and pinion, deat	d plane a th occurre	nd due to the old at the time,	date and place	narner as a e, and due t	o the cause(s)	
	To the To the comple	Me	29b. Signature and title of certifie				290	c. License	number			29d. Date sig	ned (Month,	Day, Year)	_
			Cynthia	Kuther	-Sand	0 00		D41	745	(April	28,	2006	
. ,,			30. Name and address of person		ause of death (Ite	m 23a) (Type,	Print)	Nur	sina H	ome					
)H -	(11+1		Cynthia Kuthe 31. Date filed (Month, Day, Year)		S MD WI	ature	POIT				will	amspo	Ct, M	zan Street aryland	_
	Sta Registr		MAY O	2006	A solution	A. A.	will	,							

			4 01	Department of Health and N Certificate of Death	•	ne 2006 15215						
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death						
1	/Media	cal	Arthur F. Nardelli 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 1, 200	06 12:40 A M 4c. County of Death						
	Examir	ier	Calvert Memorial Hospital	Prince Frederi		Calvert						
	Funeral Director		5. Social Security Number 151−14−6061 6. Sex 1 ★ 2 F 7. Age (In yrs. last bin 79	Mantha Dave House Min	8. Date of Birth (Month, Day, Yea Feb. 20,							
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits						
	a-fsh	ctor	Maryland Calvert No.	orth Beach		ty∑Yes 2 ☐ No						
	ith the	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?						
	eath v	eral	8933 Chesapeake Ave. B-306 11. Marital Status 12. Was Decedent Ever in U.S.	20714		JSA 14. Race - American Indian,						
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked othar than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinations by natified at	by Funeral Director	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No ARMY If Yes, Give	Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puerto □ Yes 2√√2 No Specify:	Decity res or No-	Black, White, etc. Specify: White						
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/Industry						
121	within ene. than	duic	Elementary/Secondary (0-12) College (1-4or 5+)	Optician		Eye Care						
1d 2	2 should be filed with and Mental Hygiene. is marked othar than aumatic event, Ite M	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid							
ylar	should be and Mental marked o	To E	ia									
Mar	12 sho h and 7 is m traum			. Mailing Address (Street and Number or Ru :820 Mays Landing Rd.								
	tand 27 itand 27 itam					Location - City or Town, State						
OIII	Pages nent of int: If i			C	5. 2006 P	ittsburgh, PA						
Baltimore,	permit. Pages Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEALL Funeral Home 6512 NW Crain Hwy Bowie, MD 20715									
1760,	Priyacian /Medical Examiner partial-transit partial-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause	CUNG MASS		Approximate Interval Between Onset and Death						
.O. Box 68	The law requires that the death certificate b ate has been signed by the attending physic page 2 should be detached for use as the b	Physician/MedI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year						
α.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 \(\sum No \) 3 \(\sum \sum \sum \sum \sum \sum \sum \sum						
Records,	The law re- ate has bee page 2 sho	Completed	- Chronic Statuetre	Lung de l'erre	24a. Was an autopsy performed?							
Vital	ysician: Th	Be (25. Was case referred to medi 1 examiner?		th (Check only one)							
of	Phys this al di	<u>۲</u>		tpatient 3 DOA Other: 4 Nursing He	ome 5 Residence	6 ☐Other (Specify)						
lon	nding F ith. :: After e funera	atlon		njury Work? M 1 Yes 2 No	25d. Describe now in	jury occurred						
Division	To tha Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune.	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)						
	To tha Hospital within 24 hours a To the Funaral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place, dor investigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)						
	To that within 2 To the complet	M	29b. Signature and title of certifier	29c, License number	7 5 29d. C	Date signed (Month, Day, Year)						
12	- (2)		30. Name and address of person who completed cause of death (Item 23a) (Dr. Mukash Mathur 110 Hospita									
	Sta Registr	_	Dr. Mukash Mathur 110 Hospita 31. Date filed (Month, Day, Year) MAY 0 2 2006	al Rd. #305 Prince F	rederick,	MD 20678						

			For State Registrar		-	partment of ertificate o			ene 2006	15246		
	Physici		Decedent's Name (First, Middle, Last) Francine		athan			2. Date of Death Month April 25.	Day Year	3. Time of Death 11:30 A. M		
	/Medio Examir		4a. Facility Name (If not institution Name St. Thomas More And F	Hegand number) Perabilitat	ion Center	Hyatt:	n, or Location of Dea SVII1e	ath	4c. County of Death Prince Georg			
	Funeral Director		5. Social Security Number 6. Security Number 1 S	7. Ag	ge (In yrs. last birthd 70 Yrs	Months Do				place (State or Foreign intry) ginia		
	Maryland a-f show	tor	10a. State Maryland 10b. County Prince Geo	nge's	10c. City, Town or	Location	Hyattsville	e		10d. Inside City Limits 1 AYes 2 No		
	th with the 23a or 280	al Director	10e. Street and Number 3516 Dean Drive Apt	:• #J-3		10f. Zip Code	20782	100	g. Citizen of What Cou U.S.A.	intry?		
980	n 72 hours after death with the Maryland "naturel", or Items 23a or 28e-1 show calical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 1 No	3. Was Decedent of If Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- into Rican, etc.)	14. Race - Ameri Black, White Specify:			
Baltimore, Maryland 21215-0036	be filed within 72 ho ital Hygiene. id other then "natur event, the Model	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th grade		(G 5+)	cedent's Usual Oci ive kind of work do a. DO NOT use ret	ne during most of w	orking 16		Kind of Business/Industry Carter's Food Services		
yland 2		To Be C	17. Father's Name (First, Middle, Last) Frank Jack	rson			18. Mother's Na	Mother's Name (First, Middle, Maiden Surname) Nannie Talley				
, Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (Ty Clara E. Powell (Daugh					Rural Route Number, (11 Maryland	City or Town, State, Zi d Apt. #J–3	p Code)		
imore	0 0 = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, c	sposition (Name of crematory or other p re Cremator	y, Inc. May		Oc. Location - City or T Beltsville, M			
Balti	permit. Pag Department Important: I eny injury c		21. Signature of Funeral Service Licens	Sin	_	22. Name and Ad 4339 Hunt		Rollins Funer Washington,	cal HOme, Inc D.C. 20019	•		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	a consequence of):							
.O. Box 6	at the death certifii by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (specify,			23d. Date of deliv Month	very Day Year		
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions con Henato Hi	ntributing to death I	out not resulting in th	e underlying cause	given in Part I.		cco use contribute to	the cause of death?		
of Vital Record	The taw require ate has been sip page 2 should b	Completed	Dementa	160	r cep ha	lopeit	7	24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of		
Vital	Physicien: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath (Check only one)				
	Phys this ral dii	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju		e of 28c. ir		Home 5 Residen	ce 6 □Other (Speci rinjury occurred	fy)		
ion	Attending I r death. ector: After by the funer	atlo	1 Accident 5 Pending investigation	(Month, Da	ay Year) Inju		Vork? ☐ Yes 2 ☐ No					
Division	i gite	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, tc. (Specify)	street, factory, office	ce	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,		
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sicien: To the best ner: On the basis of and manner s	of examination and/o	eath occurred at the r investigation, in m	e time, date and plac ly opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as s e and place, and due t	stated. to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and little of certifier	nles-	Ine Go	20.	onse number		d. Date signed (Month,			
			30. Name and address of person who co	eted cause of	death (Item 23a) (Ty	De, Print	NSGUNZ	Ret Hus	attoville	MO2020		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	est o						

			For State Registrar		State of	Maryland		artmen rtificat			and M		giene Reg. No.	006	15247
	Obverial		1. Decedent's Name (i	First, Middle, L								2. Date of De Month	Day	Year	3. Time of Death
	Physici /Medic		Char			Nickers	on	,				April	28	2006	9:26 a. ^M
	Examin	er	4a. Facility Name (If no			-				Location o	of Death		4c. (County of Deat	
			5. Social Security Num		Ave., #70	18 7. Age <i>(In yr</i> s. <i>Ia</i>	et hirthday)	If Under		idge	24 Hrs	8. Date of Bir	th	Dorche	
	Funeral Director		213-42-00		1 M 2 F	62 (m)	Yrs.	Months	Days	Hours	Min.	Aug.	y, Year)	943 Ma	hplace (State or Foreign untry) aryland
	_		Usual Residence of De			02						nuy.	27, 1	244 146	aryrana
-	Maryland -1 ehow livy at	_		Ob. County Dorches	at an		Town or Lo								10d. Inside City Limits
Y	Ba-1-	cto	MD	Dorches			ambri	uge				<u></u>			1 AYes 2 No
β	77 hours after death with the Marylar "natural", or Items 23a or 28a-f ehow relical Exacili at must be rediffed at	Funeral Director	10e. Street and Number		#700			10f. Zip	Code 2161	2			10g. Citiz	en of What Co	untry?
)	s 23s	ral		eor ave	e., #708	dent Ever in U.S	12				ain? (Sne	noifu Van ar Na		4. Race - Ame	rican Indian
0	Items:	-un-	11. Marital Status 1 ☐ Never Married	2 □ Married	Armed For	ces?). 13.	If Yes, spec	offy Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	,	Black, White	
936	hours after ural', or Ite	by	3 Widowed 4	_	16 Voc Gine		96	1 ☐ Yes	2 X No	Specify:				Specify: [Vhite
5-0036	72 ho	Completed	15 (Separity	5. Decedent's l			16a. Dece	dent's Usua kind of wor	al Occupa	ation	t of worki	na	16b. Kin	d of Business/	Industry
2121		nple	Elementary/Second		College (1-	4or 5+)	life.	DO NOT us	e retired) , , , , , , , , , , , , , , , , , , ,	o work	,,,g			
21	e filed within al Hygiene. I other than ' vent, I're Me	Co	12					serg	eant		ola Ninona	/Final Ministra			nal Guard
Maryland	uld be fil lental H rkad otl lic even	Be	17. Father's Name (Fit Allen Ni								rs Name lise	(First, Middle,	, Maiden S	Unknov	√n
Ž	2 should be and Mental is markad of aumatic ev	^L	19a. Informant's Nam-				19h Maili	na Address	(Street a			d Route Numb	er City or	Town, State, Z	
S	s 1 and 2 should be filed withi f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M		Wilson Too		P.R.			•					•		D 21613
ē,	s 1 ar		20a. Method of Dispos	sition			ace of Dispo	sition (Nan	ne of	1		ate		ation - City or	
mo	Pages ent of nt: If i		1 Burial 2 X		□Removal from S :ifv)	state -	sbury	-			1/29/	' 06	Sal	isbury	
Baltimore,	permit Pages Department of I Important: If its any in ury or of once.		21. Signature of Fune				22	2. Name an	d Addres	s of Facilit	y T h	omas Fi	unera	1 Home	, P.A.
m	Depa Impo any ii		Brik	: Bu			7	00 Lo	cust	Stre				D 2161	
	Physician /Medical Examiner	Iner	23a. Part1. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death) Sequentially list condition and list of the cause. Enter Underly Cause, (Disease or in)	failure. List onl nal	a	or as a consequence as a consequence or as a c	25 01 ence of 0	carbo Carbo Edulk		o, such as	ardiac d	Covy	rrest,		Approximate Interval Between Onset and Death
x 68760,	leath certificate be executed attending physician and I for use as the burial-transit	/Medical Examiner	Cause (Disease of injuly that initiated events resulting in death) Las		c. Due to (c	or at a conseque		wein	oe						Thorthe
P.O. Box	the death by the atter ached for u	Physiclan/Medical	23b. Was decedent print the past 12 months of 1 Yes 2 No. 1	onths?	1 Live bi	rth 2 ☐ Fetel	death 3[Ectopic pr Other (sp					2:	3d. Date of deli Month	very Day Year
	v requires that been signed t should be det	by	Part II. Other significa		hysene	ath but not resul	ting in the u	nderlying c	ause give	en in Part I.		23e. Did to		1/	the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed										24a. Was autor perfo 1 Yes	an osy rmed? 20X No	death?	topsy findings available completion of cause of 2 No
Vita	ilclan: Th certificate rector, pag	Be	25. Was case referred examiner?	to medical	Hospital:				Othe	200		(Check only o			
of	ing Phys n. After this funeral di	ıtlon: To	1 Yes 2 No 27. Manner of eath 1 Natural 2 Accident	5 Pending investigati	28a. Date o		R/Outpatier 28b. Time o Injury		8c. Injury Work	at Nu	4	me 5 🔀 Resid 28d. Describe I		Other (Spec	ify)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certification:		6 Could not determine	be d 28e. Place buildin	of Injury - At hor g, etc. (Specify)	ne, farm, str	eet, factory	, office		1	28f. Location (3 City or Tox		Number or Ru	ral Route Number,
	the Hospi in 24 hou the Funer pletely fill	edical	29a. Certifier 1 (Check only 2[one)	Medical Exa	Physician: To the aminer: On the ba and mann	sis of examinati	rledge, deat on and/or in	vestigation	, in my op	oinion, deal	d place, a th occurre	ed at the time,	date and p	place, and due	to the cause(s)
	To To	Σ	29b. Signature and the	of certifier	40. O.	2		290	. License	number	11		29d. Date	signed (Month	, Uay, Year)
•				r wy	- Consol				カフ	499			7	2010	Ь
			30. Name and address	s of person who	completed cause	of death (Item		Print)	LOO.	24 N	nn	EXAT	יצות.	MAA	CUN WOTERS
	Sta Registr		31. Date filed (Month,			strar's Signati		frank	٤	-7		W 12	- 0000	ין ערוע	01-, 010 (191)

				State							lental Hygi			1	1 = 21 2
			For State Registrar			Cei	tificate	of L	Death			g. Nó:	2006		5248
	Physici	an	1. Decedent's Name (First, Midd								2. Date of Death 04/25/20		/ Year		3. Time of Death
	/Medic	al	Stacy Lynn New 4a, Facility Name (If not institution		umbarl		4h City 3	Four or	Location of		04/25/20	_	6 10:20 A		
	Examin	er	2706 Birdseye		arriber)		Bow		Location of	Death		Prince Georges			
	Funeral Director		5. Social Security Number 214-80-8920	6. Sex iX M 2 ☐ F	7. Age (In yrs. 47	last birthday) Yrs.	If Under Months	1 Year	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 08/18/19	Year)		rthplace country)	e (State or Foreign
-	iand iow		Usual Residence of Decedent 10a. State 10b. County	у	10c. Cit	ty, Town or Lo	cation							10d.	Inside City Limits
	8a-f sh	Funeral Director		CE GEORGE	5 B	Bowie									1 XYes 2 No
	with th	Dir	10e. Street and Number 2706 Birdseye	Lane			10f. Zip	Code 2071	5		10		izen of What C USA	Country's	,
	ms 2:	era	11. Marital Status	12. Was De	cedent Ever in U	I.S. 13.				in? (Spe	ocify Yes or No- Rican, etc.)		14. Race - Am		
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Examinat must be natilised at	þ	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorce	If Yes C	2 X ∫No live		r res, spec 1 ☐ Yes 2		Specify:	Риепо	Hican, etc.)	Black, White, etc. Specify: White			
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nore	Pages I Iment of H tant: If Ite jury or ot		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation			cemetery, cren kemont	natory or ot Memo	her place	9)				ocation - City o vidsonv		
Baltimore,	permit. Pag Department Important: eny Injury once.		4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service			Gard	. Name and	d Addres	s of Facility	Rob	ert E. E	lvai	ns Fune	ral	Home
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P.O. Box	is that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Feta gnant at time of conown	al death 3	Ectopic pre Other (spe					4	23d. Date of de Month	elivery Day	y Year
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Vital	ysician: This certificate	Bec	25. Was case referred to medica	al					26. Place o	of Death	1 Yes 2, (Check only one	No.	1010	3 21_	3140
∑ <	S 5	2	examiner?	-		ER/Outpatien			4 Nurs		ne 5 XResider			ecity)	
on	Attending Fird death.	tion:	27. Manner of Death 1. Natural 5 Pendi 2 Accident invest	ing 28a. Dati ing (<i>M</i> o tigation	of Injury nth, Day Year)	28b. Time of Injury	м 28	Bc. Injury Work 1 🔲 Y	at ? ∕es 2 ∐ N		28d. Describe how	v injur	y occurred		
Division of	E Diff o	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Plac	e of Injury - Al h ding, etc. (Special		eet, factory,	office			28f. Location (Stre City or Town,			iural Ac	oute Number,
	ne Hospital	edical C	29a. Certifier Check only one) Certifyi	ing Physician: To the	ne best of my kno basis of examina oner stated.	owledge, death	occurred a restigation,	at the tim in my op	e, date and pinion, death	place, a	and due to the car ed at the time, da	use(s) te and	and manner a place, and du	s stated e to the	d. e cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certif	or Da	A M		290	License	nymber	504	29	d. Dat	e signed (Mon	th, Day	', Year)
			30. Name and address of person	HAID	use of death (Iter	т 23а) (Туре,	Print) (ch	aku	۷)	M	/	26 Woodya 735	ard F	d.
	Sta Registr		31. Date filed (Month, Day, Year APR 2		Aegistrar's Signa	A A	N								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 APRIL 3:00P ^M EMMA LEVON NORWOOD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES SUITLAND 4727 BROMLEY AVENUE 8. Date of Birth (Month, Day, Year) AUG. 12, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M XXF Months Days Hours Min Director 061 24 8295 78 1927 NORTH CAROLINA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23s or 28a-f show other treumatic event, the Modical Examinar must be multilled at XX Yes 2 No Director SUITLAND PRINCE GEORGES MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4727 BROMLEY AVENUE 20746 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes XX No If Yes, Give 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MATHMATICIAN GOVERNMENT 5+ permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked others any injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FORREST McKINLEY STEELE BLANCHE LILLIAN JONES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROYSTER NORWOOD / HUSBAND 4727 BROMLEY AVENUE SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) WASHINGTON NATIONAL CEM. 4/29/06 SUITLAND, MD 21. Signature of Fundial Service 22 MARSHALL ST FOUNERAL HOME OF MARYLAND, INC. SUITLAND, MD 20746 4308 SULTLAND ROAD 23a. Part it. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BLADDER CARCINOMA SIX YEARS /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes XXNo Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has a autopsy performed? Yes 22 No certificate 2 🗌 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ٩ Cthen: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 1 ☐ Yes XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide within 24 hours To the Funerel 29a. Certifier XIX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51946

State Registrar

32. Registrar's Signatur 31. Date filed (Month, Day, Year) APR 2 7 2006

address ROBERTO PILI, MD.

person who completed cause of death (Item 23a) (Type, Print)

APRIL 26, 2006

JOHNS HOPKINS HOSPITAL 1650 ORLEANS ST. BALTIMORE, MD

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Physician /Medical Examiner Henry NEWHOUSE 4a. Facility Name (If not institution, give street and number) Casey House Montgomery Hospice Funeral Director Usual Residence of Decedent Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location April 30, 2006 4b. City, Town, or Location of Death Rockville Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 4c. County of Death Montgomery 9. Birthplace (State or Foreign Month, Day, Year) Palestine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1 - Stata Registrar	State of Ma			tificate o				Rag.	C 0 1	J b	15250
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3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title pf certifier 29b. Signature and title pf certifier 29b. Signature and address of per who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855		ding l	lon	1 XNatural 5 ☐ Pending		Ye <i>ar)</i> 285. I	ime of njury	W	ork?		28d. Describe	a how in	jury occurre	∍d	
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29a. Certifier (Check only one) 29b. Signature and title pf certifier 29b. Signature and dudress of per who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of per who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855	Di	F & F C	erti	4 Homicide determined	building, etc.	(Specify)	, 5,100	or, raciory, critica						or riurar	noute reunder,
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	•	1		30. Name and address of per who	completed cause of de	ath (Item 23a) (Туре, Р	rint)							
				Joseph Kaplan, M.			Mi.	11 Road	, Ro	ckvill	e, MD	20	855		
					2006 32. Registra	r's Signature	La	alls!							

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / De	partme		alth and	-		900	6	15	251
	and the same of th	-	Decedent's Name (First, Middle, Las	t)					2. Date of	Death		-	3. Time	of Death
	Physici		LEATRICE S. NEER						Month APRIL			ear	7 • 5	O AM ^M
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City	, Town, or Lo	ocation of Deat			4c. County of Death			
	Exami	iei	8100 CONNECTICUT A		18		CHE	VY CHAS	SE		МО	NTG	OMERY	
	Funeral		5. Social Security Number 6. Se	ex 7. Ag	e (In yrs. last birthda		er 1 Year I	If Under 24 Hrs	8. Date of	Birth				e or Foreign
No.	Director	2	579-24-7728	☐ M 21公 F	79 Yrs	Months	Days	Hours Min.	MAY 1				EW YO	
	p.		Usual Residence of Decedent		100 City Town	Lacation							04 1	Oit Limite
	anylar shov	-	FLORIDA PALM	BEACH	10c. City, Town or		OCA RA	TON				- 1		City Limits es 2 ☐ No
	8a-f	Director		DEACH										.5 2
	vith th	洁	10e. Street and Number			10f. Z	ip Code			10g. C	itizen of Wh		ntry?	
	s 23s	by Funeral	5800 CAMINO DEL SO			2 14/ D		3433	S4 W		U.S		an Indian	
	er de Item	nue	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ X	Ever in U.S.	If Yes, sp	ecify Cuban,	anic Origin? (S Mexican, Puer	to Rican, etc.)	NO-		White,		
36	rs aft	J.	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 XNo	Specify:			Specify:	WH	ITE	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f show to Mudical Examer counted to recitited at	ed	15. Decedent's Ed	ucation	16a. De	cedent's Us	ual Occupation	on		16b.	Kind of Busi	ness/In	dustry	
15	n "n	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	(G	ve kind of w b. DO NOT	ork done dur use retired)	ring most of wo	rking				,	
212	d with	Completed	12	College (1-401 S	, ,	Al	DMINIS	TRATOR		TH	RADE A	SSO	CIATI	ON
	oth oth	Be	17. Father's Name (First, Middle, Last)				11	8. Mother's Na	me (First, Mide	dle, Maide	n Sumame)			
lar	Alenta Alenta rked tice	To	ALBERT KAY				M	IARY SCH	IRIER					
Maryland	shol		19a. Informant's Name/Relationship (1	•	19b. Ma	iling Addres	ss (Street and	d Number or R	ural Route Nur	nber, City	or Town, St	ate, Zip	Code)	
	and 2		BARRY N. DICKSTEIN	N/SON				ACE, PO	TOMAC,	MARY	ZLAND	20	354	
ore	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	>	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Pamoval from State	20b. Place of Dis cemetery, of	position (Na rematory or	ame of other place)	i	Date	20c.	Location - Ci	ty or To	wn, State	
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specify		KING DA	VID M	EML GD	NS 04/2	27/2006	FAI	LLS CH	URC	H, VI	RGINIA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show my high yor or other traumatic event, it a Medical Exam are unset to reclificate ones.		21. Signature of Funeral Service Licen	see		22. Name a DANZAI 1170 1	NSKY-G	of Facility OLDBERG LLE PIR	MEMOR	IAL (CHAPEL LE MA	S, I	INC.	20852
	7 1		23a. Parti. Enter the disease, or companies shock, or heart failure. List only	plications that caused							J.L. J. 1141		Approxim Interval B	
	Physician		Immediate Cause (Final										Onset an	id Death
	/Medical		disease or condition resulting in death)	u	TIC CARCI a consequence of):	NOMA							MONT	Н5
	Examiner				,									
	A CONTRACTOR	je	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequence of):									· · · · · · · · · · · · · · · · · · ·
	e be executed /sicien and e burial-transit	Examiner	that initiated events	C										
ó	en ar	EX	resulting in death) Last	Due to (or as	a consequence of):									
1760,	ate be executed nysicien and he burial-transit	cal	(d								_		
68	leath certificat attending phy I for use as the	Physician/Med	IE EENALE.											
Вох	th cel endir r use	ar/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		3 □Ectopic	pregnancy				23d. Date		-	
-	deal	SICIE	in the past 12 months? 1 ☐ Yes 2 ☐ X io	4☐Pregnant at		5 Other (s				-	Month	1	Day	Year
P.O.	requires that the death een signed by the atter nould be detached for L	h	9 Unknown											
	res tha signed I be det	by	Part II. Other significant conditions of DIABETES MELLITUS	-	ut not resulting in th	underlying	cause given	in Part I.			use contrib			
Vital Records,	w require been sly should b	ed	DIADELES MELLITOS	1111 2					11	☐ Yes	2 ₹ 1No 3	Prob	ably 4 [_Unknown
၁၁		Completed							24a. W	as an	24b. We	re auto	psy finding	s available
Ä	The ste ha	E							pe	erformed?	dea	ith?	2 No	02200 01
ita	lan: rtifice stor, I	Be	25. Was case referred to medical				2	26. Place of De						
f V	Physician: The law this certificete has t ral director, page 2 s	To	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Outpa	ient 3 🗆 🖸	Other:	4 Nursing I	Home 5□R	esidence	6 ₹ Other	(Specif	2nd	HOME
0	ter the	ii.	27. Manner of Death V☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injur	e of	28c. Injury a Work?	at	28d. Describ	e how in	ury occurred			
Division of	endir sath. or: Al	Certification:	2 Accident investigation			М		s 2 🗆 No						
Ξ	r Att	ij.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of inj	ury - At home, farm, c. (Specify)	street, facto	ry, office			n (Street a Town, Sta	and Number te)	or Rura	l Route No	ım ber,
	ital o rs aft rai Di	Ce												
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 X Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best ninar: On the basis o and manner st	f examination and/o	ath occurre investigation	d at the time, on, in my opin	, date and plac nion, death occ	e, and due to t urred at the tim	he cause(1e, date ai	s) and mann nd place, and	er as s d due to	ated. the cause	9(s)
	thin 2 the mple	Mec	29b. Signature and title of certifler	and manner sta	ated.	2:	9c. License n	number		29d. D	ate signed (Month.	Day, Year)
	F358		I I V	_ /	M		D36			1	APRIL			
	10		700			- D.:						,		
			30. Name and address of berson who JOHN J. MERENDINO				אר פוזי	TTF 405	ייזיים מ	EGD 4	MVDV	T A 1\TT	30	817
#	C.	ate	31. Date filed (Month, Day, Year)		ar's Signature	WOOD 1	.u, 5∪	11E 4U3	, DEIH	و AUGت	MAKY	LANI	, 20	01/
	Regist			2006	in the	Goode	1							

	ı		1 - For State Registrar	State of Mary		ment of He		ental Hygier	7000	15252
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medio		Brittany,	Morgan	Nevill	0		April 2	/	6:46 PM
ř	Examir		4a. Facility Name (If not institution, give	treet and number)	4	b. City, Town, or Lo	ocation of Death.	11	4c. County of Dea	th
			The Johns Hopk	in Hospita	yl X	Je y I I I I I I I	12 CI-	+4		
	Funeral Director		5. Social Security Number 6. Sex	r. Age (In]M 2-—∏F			Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) Co	thplace (State or Foreign ountry)
			214-25-1452 Usuel Residence of Decedent		1/			MARCH 11,	1989 MAI	RYLAND
	yland how		10a. State 10b. County	10	c. City, Town or Locat	ion				10d. Inside City Limits
	Marie e	ctor	MARYLAND WASHING	TON		SHARPSI	BURG			1 ☐ Yes 2 🔯 No
	ith th	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	death with the Maryland rme 23s or 28s-f show	8	3536 HARPERS FERRY				L782		U.S.A	
	ftem ftem	Funeral		12. Was Decedent Ever Armed Forces?	r in U.S. 13. Wa.	s Decedent of Hisp es, specify Cuban,	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	irs aft	by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 🗆	Yes 2⊠ No	Specify:		Specify:	WHITE
215-0036	within 72 hours after ene. then "naturel", or Ite to Medical Exercito		15. Decedent's Edu	cation	16a. Deceden	t's Usual Occupation	on	16b	. Kind of Business	
212	n n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kin life. DO	d of work done dur NOT use retired)	ing most of workir	ng		
7	or th	Completed	10			STUDENT			PUBLIC H	GH SCHOOL
Maryland	should be filed within 72 hours after death with the Marylan of Mental Hygiens. marked other than "natural", or fleme 23a or 28a-f ehow marked other than "natural", or fleme 13a or 28a-f ehow marke event, it a Medical Evaluation must be inclified at	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maid	· ·	
<u> </u>	should ind Men marke umatic	ဥ	LEROY NEVILLE JR.					VE KAY ZII		
Mai	na na na na na na na na na na na na na n		19a. Informant's Name/Relationship (Ty)	· · · · · · · · · · · · · · · · · · ·				Route Number, Cit		
	s 1 and f Health item 27 other tr		Leroy Neville Jr./ 20a. Method of Disposition		Ob. Place of Disposition	on (Name of		STOWN, MAI	Location - City or	21740 Town, State
ğ	0 0		1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cremate	ory or other place)	05/05			
altimore,	permit. Peg Department Importent: I eny injury o ance.		4 □ Donation 5 □ Other (Specify) 21. Sign sture of Fusi ral Service Loens		MOUNTALN_V	LEW CEME.				RG, MARYLAND
B	Dep per imp		Harry VA	Paul m	. Dean BAS		. HOME	7606 Old 1 Boonsboro		
			23a. Part1. Enter the disease or complishock, or heart failure. List only or	cations that caused the	death. Do not enter t	he mode of dying,			, ratytai	Approximate Interval Between
	Physician		Immediate Cause (Final	^						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	pry tail	40				& day;
п	xaminer		Sequentially list conditions,	Acute 1	respirator	y distres	is synctron	ne		6 days
	st sq	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				J			112 1
	and and Il-tran	Examln	that initiated events resulting in death) Last	Due to for as a co	insequence of):	rsplant				110 days
8760	icate be executed physicien and s the burial-transit			b) 4	anemia					10 months
89	ficate g phy: as the	edical								
ŏ	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr		topic pregnancy			23d. Date of de	livery
P.O. Box	The law requires that the death certificate has been signed by the attending page? should be detached for use as	Physiclan/Me	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time		ther (specify)			Month	Day Year
<u>т</u> О	res that the de signed by the a be detached f	Phy	9 Unknown							
Š,	signed be d	۵	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the unde	rtying cause given	in Part I.			o the cause of death?
Ö	w require been sle should b	eted	Panereatitis					-		
Division of Vital Records,	hysicien: The law his certificate hes t il director. page 2 s	Completed	Kenal tailure					24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
a	n: Th ficate r. pag		05 100 000 000 000 000					1□ Yes 2⊠		2 🗆 No
5	sicie certi irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	2 ER/Outpatient	Other	6. Place of Death	(Check only one) ne 5 ☐ Residence	2 CO+ (2	-6.1
ō	Attending Physicien: r death. ector: After this certifici by the funeral director.	F	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	+ Li reursing mon	8d. Describe how in		icity)
Ö	ath. r: Ath	atlo	1 Naturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury		s 2 🗆 No			
<u>≥</u>	if or Attend after death Director: /	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, street,	factory, office	2	8f. Location (Street City or Town, St		ural Route Number,
	ital o irs afl rai Di									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	29a. Certifier 1 Certifying Physics (Check only 2 Medical Examination)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death or amination and/or inves	ccurred at the time, tigation, in my opin	date and place, a ion, death occurre	nd due to the cause od at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License n	umber	29d. I	Date signed (Mont	h, Day, Year)
)			Kuster	Melou	Mo	XXS 0	300	A	nil 28,20	006
41	1. =		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, Prin	nt)				0.77
)r	1-5		Miske Nelson 31. Date filed (Month, Day, Year)	100 C	Signature	voice Str	ect f	Baltimore	MD of	1781
-62	Sta Registr		MAY 0 2, 200	6 Descu	Signature	EL				

State Registrar

DHMH 17 Rev 1/2001

10845 Town Center Blvd., Dunkirk, MD 20754

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Peter L. Wisniewski, M.D. 1084

26

31. Date filed (Month, Day, Year)

			For State Registrer		State	of Man	yland		artmen rtificat				lental F	lygie:	7111	06	152	54
			Decedent's Name (First	t, Middle, Las	t)								2. Date of	Death			3. Time o	f Death
	Physici /Medic		Zelma				Plu	mmer					Month May	10,	2006	Year	6:45	РМ
	Examir		4a. Facility Name (If not in	nstitution, give	street and nu	ımber)			4b. City,	Town, or	Location of	of Death			4c. County	of Death		
			Memorial 1	Hospita	a 1				Cum	ber1	and				A11e	gany		
	Funeral Director		 Social Security Number 216-22-594 		эх □м 2 ∑ F	7. Age (/ 82		t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, Aug 2	Birth Day, Ye 24, 1	923	9. Birthi Cou	olace (State	or Foreign
	pu k		Usual Residence of Dece 10a. State 10b.	County		10	Oc. City	Town or Lo	cation								10d. Inside C	ity Limite
	a Maryla ta-f eho	ctor		Allegar	ıy			Cumb		d								2 No
	a with th	Funeral Director	10e. Street and Number 11807 Croc	us Ave	nue				10f. Zip		21502			10g.	Citizen of V		ntry?	
	daati	nera	11. Marital Status		12. Was Dec		er in U.S.	13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or Rican, etc.)	No-	14. Rac	e - Ameri	can Indian,	
39	urs aftar al', or Ito	þ	1 ☐ Never Married 2 3 Widowed 4 ☐ E			2 X No ive		ĺ	1 Yes	V	Specify:		rican, ec.,			ck, White, white		
ğ	2 hou	ted	15. C	Decedent's Ed	ucation			16a. Dece	dent's Usua	il Occupa	tion			16b	. Kind of Bu			
215	thin 7	Completed	Elementary/Secondary		de completed, College	1-4or 5+)			kind of wo DO NOT us		<i>urin</i> g mos)	t of work	ing					
7	ad wi	S	12				<u> </u>	lomer	naker	•					vn Ho			
Maryland 21215-0036	2 should be filed within 72 hours efter death with the Maryland and Manile Hygiens and Manile Hygiens in a and Manile Hygiens is marked other than "natural", or Iteme 23s or 28s-f show aumatic event, the Madical Examination and constitution as	To Be	17. Father's Name (First, Cyrus He		her								orne (
Mary	parmit. Pages 1 and 2 should be Department of Health and Mania Importent: If Item 27 ie marked any injury or other traumatic ed <u>page</u> .		19a. Informant's Name/R Margaret Te		Гурв, Print) da	aught	er	19b. Mailir 1180	ng Address 7 Cro	(Street 2	Aven	or Rura UC	Route Nui Cun	nber, Cit	ty or Town, land	State, Zip	2150	2
altimore,	iges 1 ar nt of Hea i If Item	1 11	20a. Method of Dispositio	mation 3 🗆		Ctata	сеп	ce of Disponetery, crer	natory or o	ther place	9)		Date 5/12/200		. Location - umbe	-		ID
altin	irmit. Pa apartmer portent iy injury is injury		4 Donation 5 0			227	M				+ Funer		me, PA		ullibe	Hanu	IV	
<u> </u>	805 8 9		Thund	any	. Del	Upl	111						Cumb		d, MD 2	21502		
Į	Physician		23a. Part 1. Enter the dis- shock, or heart failu tmmediate Cause (Final disease or condition	ease, or comp ire. List only	one cause on	caused the each line.			er the mod	e of dying	g, such as	cardiac (or respirator	y arrest,			Approxima Interval Bei Onset and 2 day	ween Death
E	/Medical Examiner		resulting in death)			orasa c inary		nce of): .ct Ir	fecti	ion							2 day	s
	tad nsit	Examiner	Sequentially fist condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ns, ate	D	(or as a c												
8760,	be exacuted sicien and burial-transit		that initiated events resulting in death) Last		c. Due to	(or as a co	onseque	nce of):	3112		= 1.7							
	physi s tha	dicai		•	d												_	
O. Box 6	requiras that tha death certificate be exacutad nean signed by the attanding physician and hould be datached for usa as tha burial-transt	Physician/Me	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Italit		birth 2 (nant at tim	Fetal de	eath 3	Ectopic pr Other (sp					_	23d. Dat Mo	e of delive	,	Year
۵.	ras that thing and and and and and and and and and and	by Ph)	Part II. Other significant	conditions co	ontnbuting to	leath but n	not resutti	ng in the u	nderlying c	ause give	n in Part I.		23e. Di	d tobacc	o use contr	ribute to t	ne cause of o	ieath?
Records,		eted t						_						-	2 X/No		oably 4 🗍	
_	Tha lav ata has paga 2	Completed											24a. W au pe 1 ☐ Yes	topsy fromed	2 6	rior to co death?	psy findings mpletion of a 2 No	available ause of
Vital	icien cartifi actor	Be	25. Was case referred to examiner?	-	Hospitat:	,				Othe	· ·		(Check on					
ō	Phys this ral dir	2	1 Yes 2 No		28a. Date	Inpatient of Injury		Outpatier 8b. Time of			4 🗆 140		me 5 Re 28d. Describ				y)	
5	oling h. Aftar funar	tion		Pending investigation	(Mor	th, Day Y	ear)	Injury	M	Bc. Injury Work	(es 2 □		280. 1765011	H WOII B	nury occurr	e 0		
Division of	el or Attending Physicien: s after daath. l Director: After this cartific ad in by the funaral diractor,	Certification;		Could not be determined	28e. Ptac	e of tnjury ling, etc. (:	- At hom Specify)	e, farm, str						n (Street Town, St		er or Rura	A Route Num	iber,
	in Section	Medical C	29a. Certifier (Check only one)	ertifying Ph Medical Exem	ysicien: To the liner: On the liner	e best of n pasis of ex	amination	edge, death n and/or in	occurred restigation,	at the tim	e, date an pinion, dea	d place, th occurr	and due to the	he cause ne, date a	e(s) and ma and place, a	nner as s and due to	tated. the cause(s	5)
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	O		30. Name and address of	person who			_	3a) (Type,	1				_			-		
	8		Dr. William							land	, MD	215	02					
	Sta Registr		31. Date filed (Month, Da	y, Year)		legistrar's		· Ka	and I									-

_			1 - For State Registrar		ate of M	arylar		artment o				Re	g. No	006	152	55
	Physici	an	Decedent's Name (First, M.	A							N	ate of Deat	Day	Year	3. Time of D	eath
	/Medic	al	Mary Elizabe 4a. Facility Name (If not institu					4b. City, Tow	n, or Lo	ocation of D		ril	25 4c. Coi	2006 unty of Death	1605	IVI
	LAdillii	्र	Atlantic Gen	eral Hos	spital			Berl	in				W	orcest	er	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2			iast birthday) Yrs.	If Under 1 Ye Months Da		f Under 24 I Hours N	Vin. (A	ate of Birth Month, Day,	Year)	9. Birthp	lace (State or F	oreign
	Director		220–26–3709 Usual Residence of Decedent			76	113.				Ja	n 20,	1930	M)	
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	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Health and Mental Hygiene. Health and Mental Hygiene. Other traumatic avent, the Medical Examiner must be notified a	Funeral Director	11. Marital Status	12. W	as Decedent med Forces?	Ever in U	I.S. 13.	Was Decedent If Yes, specify (anic Origin	? (Specify)	res or No-	14.	Race - Americ		
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	es 1 and 2 : of Health ar f Item 27 is r other trau		Robert L. Pur				1	Stephe						in MD		
Baltimore.	of He of He if Item		20a. Method of Disposition 1 \(\mathbb{R}\) Burial 2 \(\mathbb{C}\) Cremati	on 3 DBemov	al from-State	1 ,	Place of Dispo cemetery, crei	osition (Name o	f place)		Date	2	20c. Locati	on - City or To	wn, State	
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Bal	permit. Pages I Department of H important: If Ite any injury or ot once.		21. Signature of Funeral Serv	Dulato	ind.		L	2. Name and Acewis N_{ullet}	Wat	tson I						
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	/Medical Examiner		resulting in death)	(a	Due to (or as	a consec	quence of):	1.	1.						· · · · · · · · · · · · · · · · · · ·	
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	death e etten d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ №6	10	Live birth Pregnant a	2 Feta	aldeath 3	Ectopic pregna Other (specify					23d.	Date of delive Month	Day Yea	ır
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Pec	he faw s has l ge 2 s	Completed									- ²	4a. Was ar autopsy perform	/	b. Were autor prior to con death?	osy findings ava npletion of caus	alable se of
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Eddie Louise PIERSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20°06 Physician 12:58 AM 20. EDDIE LOUISE PIERSON pril /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Yrs. AUG. 08, 1942 NORTH CAROLINA Director 242 68 8466 63 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28a-f ehow the Medical Examinar must be positived at 10d. Inside City Limits MD PRINCE GEORGES XXYes 2 □ No SUITLAND Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5208 BELGREEN STREET 20746 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. of filed within 72 hours after I Hyglene.

other then "natural", or Ite 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK þ 3 Widowed 4 Divorced eted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental WILLIAM ED FLOWERS JULIA DUNN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other trau CLINTON PIERSON / HUSBAND 5208 BELGREEN ST. SUITLAND, MD 20746 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 04/27/2006 CLINTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. S 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer ain /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes XXNo 2 No of Vital 1 🗌 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: XX Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes XXNo 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1XXNatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft To the Funeral Di completely filled in XIX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zu Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31357 30. Name and address of person who completed cause of ceath (Tem 23a) (Type, Print) 8118 GoodLuck Road Lanham Md 20106 Washington 31. Date filed (Month, Day, Year) 2. Registrar's Signatur State APR 28 2006 Registrar

			_ FOF	partment of Health and M		
	Physici	an	1. Decedent's Name (First, Middle, Last) FRANK GLEN PRUDEN	ertificate of Death	2. Date of Death	Lay 2006 4, 29 PM
	/Medic		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
- 4			DOCTORS COMMUNITY HOSPITAL	LANHAM		PRINCE GEORGES
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 1. Age (In	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, AUG. 09,	year) 9. Birthplace (State or Foreign Country) VIRGINIA
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	a-feh	ctor	MD PRINCE GEORGES LANHAM			XX Yes 2 □ No
	death with the Maryland me 23a or 28a-f ehow must be notified at	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	eath v		6615 MAGNOLIA TERRACE 11. Marital Status 12. Was Decedent Ever in U.S. 13	20706	pecify Vas or No.	UNITED STATES 14. Race - American Indian,
	be filed within 72 hours after death with the Marylan Hygiene. do other than "natural", or Iteme 23e or 28e-1 ehow event, the Medical Exam in must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married XX Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 No 1952- If Yes, Give Year or Dates: 1953	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes XX No Specify:	Rican, etc.)	Black, White, etc. Specify: BLACK
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		Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M.	aiden Sumame)
5	should by ind Menta ind marked imatic ev	은	LEE PRUDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	MAKTHA illing Address (Street and Number or Ru	NICHOLS	City or Town, State, Zio Code)
S	nd 2 lith a 27 is			15 MAGNOLIA TERRACI		M, MD 20706
e G	of Head of Head fitem rothe	. 3	20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, comments of the commen	position (Name of rematory or other place)	Date 2	Oc. Location - City or Town, State
Бапппо	Pagiment			IVET CEMETERY 04/2	8/2006 _	WASHINGTON, DC
Da	permit. Pages 1 a Department of He Important: If Item eny injury or oth		21. Signature of Funeral Savy Licenses	22. Name and Address of Facility MARSHALL'S FUNERA 4308 SUITLAND ROA	AD SUIT	LAND, MD 20746
	hysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not each shork or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) Due to (onas a consequence of):	enter the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death
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ecords, P	w requires that the di been signed by the should be detached	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
Lecc	iicien: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed			24a. Was an autopsy perform	prior to completion of cause of
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	To the Hospital or Attending Phy within 24 hours attendeath. To the Funerel Director: After this completely filled in by the funeral or	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To To Within Complete	Me	29b. Signature architer W	29c. License number <i>MOD 33983</i>		d. Date signed (Month, Day, Year) 4/22/06
ب	4		30. Name and address of person who completed cause or death (Item 23a) (Typ VIA. To frey Hond 517 Muin	e. Print) Street Suite 35		-
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2006	W		

DHMH 17 Rev 1/2001

1121 -

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Day Month Year **Physician** 1:10 A 2006 NORMA POMS APRIL 24, /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY CASEY HOUSE ROCKVILLE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M 2 1 F 82 FEB 15, 1924 MARYLAND Director 577-22-2198 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County al Hygiene.
It Hygiene.
cther than "natural", or Iteme 23a or 28a-f ehow MARYLAND MONTGOMERY SILVER SPRING 1X Yes 2 No Director the 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if I tem 27 ie marked other than "natural" ~ " any injury pootber traumatic average to the contract of the contract 15121 GLADE DRIVE APT 2B 20906 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: WHITE If Yes, Give Year or Dates: Specify: Completed by 3 □XVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER GROCER-DELI 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EVA "UNKNOWN" HARRY SCHECTER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALAN M. POMS/SON 521 MANDALAY AVE #1007, CLEARWATER BEACH, FL 33767 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State UNITED HEBREW CEMTRY 04/26/2006 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Simalare of Fur eral Service Licensee 22. Name and Address of Facility
DWARD SAGEL FUNERAL DIRECTION, INC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND _20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a NON HODGKINS LYMPHOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for sela consequence of) Examiner anding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 XNo 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ⚠ Other (Specify)HOSPICE Certification; To 1 ☐ Yes 2 ☐XNo 28c. Injury at Work? 28a. Date of Injury (Молth, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a
To the Funerel I
completely filled 29a. Certifier (🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dile to the dailsa(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D35635 APRIL 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH KAPLAN, md, 6001 MUNCASTER MILL RD, ROCKVILLE, MARYLAND 31. Date filed (Month Day Year) 32. gistrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) April 2006 PETER 10:24A M LAZARUS BENJAMIN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Burtonsville Holy Cross Rehab If Under 1 Year | II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15, 1 Birthplace (State or Forei Country) PAKTST 7. Age (In vrs. last birthday) 5. Social Security Number Days **₽AKISTĂN** Hours Min. Months 1⊠M 2□F 1935 217.33.7029 71 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1⊠Yes 2 No Burtonsville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20866 U.S.A. 14913 Falconwood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Asian 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Years Healthcare Services Elementary/Secondary (0-12) Xray Technician 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peter Mariam Benjamin Peter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14913 Falconwood Drive, Burtonsville, Maryland 20866 Rita Murhutta/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State George Wash. Cemetery 04/27/2006 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dentire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinson's Disease Due to (or as a consequence of)

Physician /Medical Examiner

death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a, State

Funeral

Director

in than "netural", or Items 23s or 28s-f show the Medical Examiner must be notified at

I Hygiene.

mit. Pages 1 and 2 should be filed w pertment of Health and Mental Hygier portant: if item 27 is marked other the y Injury or other traumatic event, ILL.

permit. Page Department o important: if eny injury or once.

Direct

Funeral

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Completed

Be

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and Il-tran physicien arts the burial-t ettending pl ed by the e

4

Sequentially list conditions, lary called 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of o 9 □ Unknown	el death 3 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 💆 Unknown			
				24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	OCA Other: 4 🖾 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory)	ery, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
29a. Certifier 1 ☑ Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the cause(scurred at the time, date an	s) and manner as stated. nd place, and due to the cause(s)

29c. License number

D-52261

29d. Date signed (Month, Day, Year)

April 26, 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

an

Alan R. Segal, MD,

29b. Signature and title of certifier

			For State Registrar	State of Mai	ryland	-	artment of H tificate of L		and Mental	Hygie Reg.	- Z U U	16	15	260
	Dhusisi		1. Decedent's Name (First, Middle, Last)				0		2. Date		Day	Year	3. Time o	of Death
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п	Funeral		5. Social Security Number 6. Sex 10	M OF XE	(in yrs. ii 55	ast birthday) Yrs.	Months Days	Hours	Min. 8. Date (Mont	h, Day, Ye	1951	Cou	place (State intry) hingto	
	Director		Usual Residence of Decedent						Dan.		1331		niing co	
	yland yland		10a. State 10b. County		10c. City	, Town or Lo	cation		· · · · · ·				10d. Inside C	
	Marfel I	tor	Maryland Anne Aru	nde1		Crofto	n						1 🗆 Yes	2 ⊒ ¥No
	or 28,	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of W	/hat Cou	intry?	
	th wi	a	2428 Vineyard La				21114				USA			
	r dea	Funeral		Was Decedent Ev Armed Forces?		S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig ın, Mexican	gin? (Specity Yes , Puerto Rican, etc	or No- c.)		- Ameri k, White,	ican Indian, , etc.	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:)		1 ☐ Yes 2 ☒ No	Specify:			Specify:	Wh	ite	
215-0036	72 hours after death with the Maryland naturel; or items 23s or 28s-f ehow disal Examinar must be notified at		15. Decedent's Educ			16a. Dece	dent's Usual Occupa	ation		168	. Kind of Bu	siness/lr	ndustry	
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	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)						r's Name (First, M			э)		
yla	should b	횬	Dominic A. Sauro			T			Maria J.					
Maryland	2 sh and te m		19a. Informant's Name/Relationship (Typ				ng Address (Street a							
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ŏ	nation of h		13€ Burial 2 Cremation 3 □ Re	moval from State	Cé	emetery, crer	matory or other place even Cemeter	1 1	May 1,					7
Baltimore,			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	•	Gale				2006				ng, Ma	ryland
Ba	permit. Depertr import. eny inj		1 Robert ERa	mey		50	Name and Address Tancis J. O Univers	sity 1	Blvd, W,	Silv	ome Ir er Spr	ic.		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to e cause on each line	he death e.	n. Do not ent	er the mode of dyin	g, such as	cardiac or respirat	ory arrest,			Approxima Interval Be Onset and	tween
J	Physician		Immediate Cause (Final disease or condition resulting in death)	Branchi	Oli	lis 1	OblitER	ons					14844	2
	/Medical Examiner		resulting in dealin)	Due to (or as a	consequ	uence of):	/.						2	
		er	Sequentially list conditions,	Due to for as a	consequ	PLAM1	<u> </u>						> YEA	125
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Bennah	بهوهوه	Lici							3 YEAR	net
	certificate be executed ding physicien and ise as the burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a	consequ	uence of):							u yex	1145
8760,	e be /siciel	cai	L d											
9	tificat og phy as th	edi												
Вох	ih cer endin r use	N/OR	23b. was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2			Ectopic pregnancy	,			23d. Date		,	
	that the death certific ed by the ettending p detached for use as f	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at ti			Other (specify)			_	Mon	th	Day	Year
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Division of Vital Records,	sign sign d be	þ	Part II. Other significant conditions cont RENAL FAILURE	nouting to death but	not rest	ulang in the u	noerlying cause give	en in Pan i.		1 Tes		3 Pro		Unknown
900		Completed							24a.	Was an autopsy	24b. W	Vere auto	opsy findings	available
æ	The ete h	E O							10	performed res 2€	1? d	eath?	2□ No	
/ita	cien: ertific ictor,	Be (25. Was case referred to medical examiner?						of Death (Check	only one)				
7	Physicien: this certific al director,	မ	1 Tes 2 100	ospital: 1 Inpatien		ER/Outpatier		4 🗀 190	rsing Home 5				fy)	
Ä	ling F	0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	Worl			cribe now	njury occurre	30		
Sign	Attending r death. sctor: After y the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	nu - At ho	omo farm et		Yes 2 □ I		ion (Stree	t and Numbe	or Or Bu	al Route Nur	nhor
)i	or A after Direction by	Certification:	4 Homicide determined	building, etc.	(Specify	y)	eet, factory, office		City	or Town, S	tate)	ii oi rigi	ar rioble repr	nber,
_	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Co	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin	er: On the basis of e	examina	wledge, deat tion and/or in	h occurred at the tin	ne, date an pinion, dea	d place, and due to th occurred at the	the caus	e(s) and mar and place, a	nner as :	stated. to the cause(s)
	thin 2 the mplei	Med	one) 29b. Signature and title of certifier	and manner state	ed.		29c. License	e number		29d.	Date signed	(Month	Dav. Year)	
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State

Registrar

31. Date filed (Month, Day, Year)

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	1	For Amend Ite State Registrar	m State of Ma	Drang.	855°,0 Cert	ificate	of L	ib Death	ina ivie	піаі ну	Reg. No.	06	15262
	1.	Decedent's Name (First, Middle, La	st)						2.	Date of De Month	eath Dav	Year	3. Time of Death
Physician /Medical		Phillip	Larry	Rar	nsey					04	28 2	006	15:38 M
Examiner Funeral		1. Facility Name (If not institution, gives Social Security Number 6.5	T HOSPITE ex 7. Age	(In yrs. last		4b. City, To	SEP Year	AUO Il Under:		Date of Bi	ALL	EGAN 9. Birth	place (State or Foreign
Director		213-34-4200	XM 2□ F 6	9	Yrs.	Months	Days	Hours	Min.	Mar 1	3, 1937	000	MO
Maryland a-f ehow Illied at	1	sual Residence of Decedent Da. State 10b. County Allega	iny	10c. City, To	own or Local Cresa		n		·				0d. Inside City Limits 1 Yes 2 □ No
with the	1	De. Street and Number 13603 Brant Roa	d SW			10f. Zip C		2150	2		10g. Citizen of	What Coul	ntry?
ind 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other then "naturel", or iteme 23s or 28s-f show traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	١.	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 TYPes 2 No. 1 TYPes, Give Year or Dates:		1	as Decede Yes, specif	nt of His y Cubar		gin? (Specif i, Puerto Ric	y Yes or Ne an, etc.)	Spec	ace - Americack, White,	etc.
ed within 72 houygiene. Net then "nature It, Ibe Medical Completed		15. Decedent's E (Specify only highest gr.		+)	6a. Decede (Give k life. De	ind of work O NOT use	done di	uring most	t of working		16b. Kind of		onWorker
12 should be filed within hand Mental Hygiene. 7 is marked other then "I reumatic event, the Mestremment To Be Comple	1	7. Father's Name (First, Middle, Last Playford Marsh							anor L		, Maiden Suma Baker	ıme)	
d 2 should Ith and Men T is marke traumatic		9a. Informant's Name/Relationship (Billie Ramsey	Type, Print) wife	1	19b. Mailing	Address (Street a	nd Numbe	or or Rural R	oute Numb	er, City or Town	n, State, Zip MI) Code) D 21502
permit. Pages 1 and 2 should Department of Health and Men Importent: if Item 27 is marke any Injury or other traumatic. SIDE.	2	Da. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specia		20b. Place	e of Disposi etery, crema awn Me	ition (Name	of er place	a)	Date		20c. Location	- City or To	
permit. Departn Imports eny Inju	2	1. Signature of Funeral Service Lice	1. Maro	OD-	22.				ral Honvenue:		erland, MI	21502	2
ificate be executed g physicien and es the burial-transit edical Examiner		23a. Part1. Enter the disease, or consolock, or heart failure. List only mediate Cause (Final disease or condition esulting in death) Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury aut initiated events esulting in death) Last	b. Due to (or as a	CONSEQUENT CONSEQUENTS	ce of): Covie Coult	3 3	ьbтт	actor	cardiac or re		arrest,		Approximate Interval Between Onset and Death
Attending Physician: The law requires that the death certific sr death. •ctor: Atter this certificete has been signed by the attending p by the funeral director, page 2 should be deteched for use es the funeral Tro Be Completed by Physician/Mec	1 2	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de	ath 3 □£	Ectopic pre Other <i>(spe</i>						ate of delivionth	ery Day Year
quires that n signed b uid be dete	, P	art fl. Other significant conditions	contributing to death bu	t not resuftin	ng in the und	derlying ca	use give	n in Part I.			tobacco use co Yes 2 □ No		he cause of death? pabfy 4 □Unknown
The law requir	-									24a. Was auto perf 1 ☐ Yes	s an 24b opsy ormed? 2 No	. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of 2 No
certifi ector	2	5. Was case referred to medical examiner?	Hospital:				Othe		of Death (C				
Physic or this c aral dire	2	1 ☐ Yes 2 No 7. Manner of Death	28a. Date of Injun (Month, Day		Outpatient b. Time of		o. Injury Work	7 110			how injury occu		(y)
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page Medical Certification; To Be Com		Natural 5 Pending investigation Suicide 6 Could not to determined	n Real Place of Injur	ry - At home	Injury	М	1 🗆 1	:? ∕es 2 □			(Street and Num wn, State)	nber or Rur	al Route Number,
To the Hospitel or A within 24 hours after To the Funeral Directompletely filled in by Medical Certif		29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner state	examination	dge, death and/or inve	occurred a estigation, i	t the tim	e, date an pinion, dea	d place, and th occurred	d due to the at the time	cause(s) and r , date and place	nanner as s e, and due t	stated. o the cause(s)
To the within To the comple	2	9b. Signature and title of certifier			CRITH	CAL 29c.	License	number	355		29d. Date sign	ed (Month,	Day, Year)
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4		STANLEY JO	EPH MAT	YASIIC	0.0	nint)	اع	IMBE	RLAN	ים, פי	MARYL	AND	21502
State		MAY 1 5 2006	32. Registra	s Signature		p							

		1 - State Registrar Amend Item 18tate of Maryland / Department of Health and Inf., G855, Certificate of Death	Mental Hy	-	15263
Physic /Medi		1. Decedent's Name (First, Middle, Last) Francisca Ramirez	Month	27, 2006	
Exami Funeral Director	ner	4a. Fecility Name (If not institution, give street and number) Washington Adventist Hospital 5. Social Security Number 6. Sex 1 □ M 2 □ F 67 Yrs. 4b. City, Town, or Location of Death Tacoma Park If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Bir	4c. County of Dea Montgome th 9. Bi 19. 7947 E1	
D		216-65-0257 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Lanham			10d. Inside City Limits Yes 2 □ No
ad within 72 hours after death with the Maryland giene. er than "natural", or items 23s or 28s-f ahow i, the Madical Expirative rount be notified at	ited by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	no Rican, etc.) Salvador	Black, Wh	or lerican Indian, ite, etc. spanic
d 2 should be filed within 7 d 2 should be filed within 7 file and Menla! Hygiene. 27 is marked other than "n traumatic avant, the Mod	Be Completed	17. Father's Name (First, Middle, Last)	me (First, Middle) a Ramire:	Domestic , Maiden Surname)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avant, the Madical Examinat Gasts be notified at once.	Т	19a. Informant's Name/Relationship (Type, Print) Elvis Ramirez (son) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Apparture of Fundation 1 Funeral Service of Section (Section of Section of Sect	sville, Date /2006 nta Cruz	MD 20783 20c. Location - City o Aguas Cali E 1 Salvado Servicios	or Town, State entes,La Unic or Funerarios,I
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death certific e attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 1 □ Vision 1		23d. Date of de Month	elivery Day Year
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To the Hospital or Attending Physicien: Twithin 24 hours after death. To the Funeral Director: After this certificel completely filled in by the funeral director, p	ation: To B	1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing N		idence 6 Other (Sp how injury occurred	ecity)
tal or Atta s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Number or F wn, State)	Rural Route Number,
na Hospital n 24 hours a na Funeral C	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred and manner stated.			
To II withi To II	×	29b. Signature and title of certifier 29c. License number	17	29d. Date signed (Mor	nth Day, Year)
R(2))	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, M.D.; 7610 Carroll Avenue; Suite 205	5; Takoma	a Park, Mar	yland 20912
S Regis	tate trar	31. Date filed (Month, Day, Year) 2. Registrar's Signature—			

		1 - State Registrar 1. Decedent's Name (First, Middle, La.	State of Man		artment of F		,	Reg. No.	006	3. Time of Death
Physic /Medi		David Ken					April		2006 ^{Year}	4:15 P
Exami		4a. Facility Name (If not institution, giv. 326 Dew Drop La	e street and number) ane		Prince	Freder:	ck		ounty of Deat Calver	
Funeral Director		5. Social Security Number 6. S 577–44–1593 1 Usual Residence of Decedent	'	n yrs. last birthday 73 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day Mar. 27	7, 193	Co	nplace (State or Forei untry) AShington,
Maryland a-f show	ctor	10a. State 10b. County MD Calve:		Oc. City, Town or L Prince	ocation Frederick	Z		-	_	10d. Inside City Limit
th with the 23e or 28	Funeral Director	10e. Street and Number 326 Dew Drop La	ane		10f. Zip Code 2067 8	3		10g. Citizer	of What Co USA	untry?
be filed within 72 hours after death with the Maryland tall Hygiene. Indicate than "naturel", or Items 23a or 28s-f show event, Ira Medical Exacult set metter than an	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		Race - Ame Black, White pecify:	
India yidiid A. I.A. I.D. 2000 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 ie marked other than "naturel", or traumatic event, ire Medicel Exert.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	edent's Usual Occup e kind of work done o DO NOT use retired	durina most of wo		16b. Kind	of Business/	industry
yianu A ould be filed Mental Hygi Mrked other patic event, I	To Be Co	17. Father's Name (First, Middle, Last) Theodore		Roth		Mayme	ne (First, Middle,	Maiden Su	mame)	Schellin
		19a. Informant's Name/Relationship (Margaret Roth (V			ing Address (Street) Wew Drop L					(ip Code) 2067 8
permit. Pages 1 a Department of Hec Important: If Item eny injury or othe		20a. Method of Disposition 1 🙀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Disp cernetery, cre Ft. Linc	osition (Name of matory or other place of oln Cem.	<u>_</u>	il 26 006		ion - City or wood.	
permit. Departr Importa eny Inji		21. Signature of Funeral Service Licental Control of 1	see	8	2. Name and Addres 125 South	ss of Facility Le ern Mary	e Funera	1 Hom	e Calv	vert, PA MD 20736
Physician / Medical Examiner and physician and physician and the printing from the printing of	Ical Examiner	Immediate Cause (Finaf disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	onsequence of):	rond of	Rifat Li	y stag	e TIL P		Syrs Mc
ath certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d.	Date of deliment	very Day Year
w requires that the de been signed by the s should be detached	by	Part fl. Other significant conditions co	ontributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.		bacco use des 2 □ N	N	the cause of death?
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or Attending Physicien: after death. Director: After this certificat in by the funeral director,		27. Manner of Death 1. ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye		f 28c. Injury Work	y at	28d. Describe h			1197
To the Hospitel or Attending Physicien: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, st Specify)	reet, factory, office		28f. Location (S. City or Town	treet and Ni n, State)	umber or Rui	ral Route Number,
the Hospitel hin 24 hours a the Funeral I	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or in	h occurred at the time evestigation, in my op	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and late and pla	d manner as ce, and due	stated. to the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier	yeurs (M))	29c. License	e number		9d. Date si	gned (Month	4
15		30. Name and address of person who con David J. Haidal			Print)	linton	MD 2073	5	· · · · · · · · · · · · · · · · · · ·	
Sta Regist	.31	31. Date filed (Month, Day, Year)	32. Registra	Signature						

State of Maryland / Department of Health and Mental Hygiene ? () ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Elizabeth Redden 0930 M 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Modical SALISON PENINSULA REGIONAL HICOMICS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 5/21/1916 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 TF 89 218-20-8339 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28s-f ahow the Medical Examiner must be notified at Maryland Wicomico Salisbury 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26170 High Banks Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, While, etc. 11. Marital Slatus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care permit. Pages 1 end 2 should be filled. Department of Heelih and Mantal Hilled. The many injury or other any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis F. Redden Ethel H. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Eugene Redden/brother 615 Sherwood Circle, Salisbury, MD 21804 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/29/06 4 Donation 5 Other (Specify) Parsons Cemetery Salisbury, MD 21. Signature of Funeral Service Lee see Name and Address of Facility
Holloway Funeral Home Professional Association Kerth 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tract inknown UNINONY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? denentia 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1□ Yes of Vital 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicism: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and in anner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30853 26/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula Regional Medical Center Salisbury my 21801 Charles B, Silvia, Jr. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2 8 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 15266

		I- For State Registrar		Cen	tificate of	Death		Re	eg. No.	100 1070
Physicia Medical Examir	11/4	1. Decedent's Name (First, Midd Matthew Aar						2. Date of Dea Month May 7, 20	Day Year	3 Time of Death 1405 hrs
		4a. Facility Name (if not institution 829 Bradock Avenue	on, give street and nur	nber)	4	b. City, Town, o		f Death	4c. County of Allegany	Death
Funeral Director		5 Social Security Number 2 1 9 - 8 8 - 4 5 1 9	6. Sex	7. Age (In yrs. Ia 29	ast birthday) Yrs.	If Under 1 Ye		Min.		9. Birthplace (State or Foreign Country) MD
ith the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent 10a. State MD A11e 10e. Street and Number 829 Braddock		1	Town or Location		002	11	0g. Citizen of What	10d. Inside City Limits 1 X Yes 2 No 1 Country?
irs after death w ural", or items miner must be	d by Funeral	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Div 15. Decedent's Education (Spe	arried Armed For 1 Yes vorced If Yes, Give Year or Dates:	2 XX No	1 1 16a. Decedent	Yes 2 X No	n, Mexican, specify: ation (Give k	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - 2 White, 6 Specify:	White
21215-0036 ould be filed within 72 hot 3 Mental Hygiene r marked other than "nat ic event, the Medical Exa	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle.		4 or 5+)	Labor	est of working life		use retired) s Name (First, Middle, N	Hardwar	e Store
121 Id be fi Aental J narked	Be	Edward Willia 19a. Informant's Name/Relations	am Robey		19h Mailing	Address (Stra	Kath:	leen Rita V	√ilev	Pieto Zin Code)
MD nd 2 sh alth and m 27 is		Kathleen Wiley- 20a. Method of Disposition		loop p	823 Br	addock	Road;	Cumberland	1, MD 21	502
토르를등등 4 Donation 5 Other Specify: IScarpelli Crematory 05/09/2006 Cres									<u>Cresap</u>	town, MD
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Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	halation		e mode or dying	g, such as ca	ardiac or respiratory arri	est, snock, or neart	Approximate Interval Between Onset and Death
× ./	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	· ·):					
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D.O. Box 68760, that the death certificate by and by the attending physic detached for use as the bur	Physician/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	he 1 Live bi	utcome of pregr rth ant at time of dea wn	2 Fet	al death 3 ner (Specify)	Ectopic	pregnancy	23d. Date of de Month	elivery Day Year
ires that the signed by the detache		Part II. Other significant condit	tions contributing to	death but not re	esulting in the u	nderlying cause	given in Par			te to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use at	Completed by							1 Yes	rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
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Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certific	4 Homicide dete	ld not be 28e. Place (Specify)	of Injury - At ho House	ome, farm, stree	t, factory, office	building, etc	c. 28f. Location (8 or Town, S Cumberlan	tate) 829 Brad	or Rural Route Number, City Idock Rd
To the Hos within 24 h To the Fun completely	Medical (one) 2 Medical Exa	aminer:On the basis o and manner st	f examination ar		ion, in my opinio	n, death occ	ce, and due to the caus curred at the time, date	and place, and due	to the cause(s)
	Σ	29b Signature and title of certific	er				se number		May 8, 2006	(Month, Day, Year)
			sistant Medical E	xaminer	111 Penn S	treet, Baltim	ore, MD 2	21201		
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 5 2		gistrar's Signatu	re	,				•
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			1 - For State Registrar	State of Maryla	nd / Department of Certificate o		, ,	ene a. No.2 () () ()	15267
	Physic /Medi	cal	Decedent's Name (First, Middle, La: Linda Lee 4a. Facility Name (If not institution, give	Rudo1ph	All Ch. T		2 Date of Death Month April 27		3. Time of Death 4:09 p
	Examir Funeral Director	ner	Civista Medical 5. Social Security Number 6. S	Center ex 7. Age (In yrs			8. Date of Birth Month, Day, Y	4c. County of Death Charles 9. Birth Con	nplace (State or Foreigi untry) KY
	pu »	tor	Usual Residence of Decedent 10a. State 10b. County MD Char	10c. C	Sity, Town or Location Hughesville	БСРСС	mider 27	,1945	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23s or 28s-f show	ai Director	10e. Street and Number 14129 Beverly		10f. Zip Code 206		100	g. Citizen of What Col	untry?
λ 5-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show may injury or other traumatic event. The Medical Examination into the indiffed at anges.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2√☐ No If Yes, GiveX Year or Dates:	U.S. 13. Was Decedent of If Yes, specify Control of Yes 2 📈	of Hispanic Origin? (Spouban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	ican Indian, n, etc. nite
/ ph	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	ducation de completed) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti Nurse	cupation ne during most of worki ired)	ing	b. Kind of Business/li	·
Maryland 2	1 end 2 should be filed withir Health and Mental Hygiene. em 27 is marked other than ither traumatic event, the Ms	To Be Co	17. Father's Name (First, Middle, Last) John Symon			Nancy S	g (First, Middle, Ma Symon	iden Sumame)	
	is 1 and 2 sh of Health and Item 27 is m		19a. Informant's Name/Relationship (Carlton Rudolp 20a. Method of Disposition	oh/Husband	19b. Mailing Address (Stre 14129 Bever Place of Disposition (Name of committery, crematory or other p	erly Dr.	Hughesv		20637
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	F ≱ ∓ 8		30. Nime and address if per in who o	completed cause of death /lea	D206			pril 28,	
1	B15		George H. Wathen,	MD, 11345 Per	mbrooke Sq., St	te. 103, Wa	aldorf, M	D 20603	
413	Sta	te	31. Date filed (Month, Day, Year)	32. Jegistrar's Signa	ature				

			For State	State of Mar	-	artment of Healt		2006	15268
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Maryland 21215-0036	₩ da ta	Be c	Spencer					ie Young	
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Division of	or Att after d Direct In by I	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 28e. Place of Injury building, etc.	(Specify)	reet, factory, office	28f. Location City or	n (Street and Number or Rur Town, State) Scuther	al Route Number
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	To To To	Σ	29b. Signature and title of certific	ar 2		29c. License numb		29d. Date signed (Month,	
J	13)					165	36	04 19 0	6
	STE		30. Name a address of person	who leted cause of dea	th (Item 23a) (Tyge	#22 C	Green St	Baltimore, M	D 21201
	<i>S</i>		Jule	100901011		"22 3.	orcen bes	Dareimore, Fi	D 21201
	Sta		APR 2 7 2006	32. Registrar	s Signature				
160	Registr	al .	*** ** ~ * ZUUU	MINERAL DE	ALIE COL				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month / Kivers Kessie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town or Location of Death Examiner Genesis Charles Mursing lata 0 racilit(Ca. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year) Nov. 12,1937 5. Social Security Number 6. Sex Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 228-58-8889 68 Yrs. Director Petersburg, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Yes 2 □ No Be Completed by Funeral Director Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5712 Cloverleaf filed within 72 hours after death 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bureau Of Elementary/Secondary (0-12) College (1-4or 5+) Currency Examiner Engraving rmit. Pages 1 and 2 should be filed with partment of Health and Mental Hygies portant: If tem 27 is marked other to yinjury or other traumatic event, in tem. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Davis Bessie Hatcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ferguson-Lyles (Daughter) 5712 Cloverleaf Ave. Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 5/1/06 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Libensee Austin Royster Funeral Home any Ir 3821 14th St. NW Washington, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) DC 20011 Approximate Interval Between Onset and Death Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): Box 68760. physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2X No 1 Yes 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

and address of person who completed cause of death (ttem 23a) (Type, Rrint)

32. Registrar's Signature

			1_ For	State of Maryla	ind / Dep	artment of	Health and	•	-	15270
			Registrar 1. Decedent's Name (First, Middle, L	a st)		rtificate c	Death	2. Date of De	Reg. No.	
	Physic /Medi	cal	Mary Margaret R 4a. Fecility Name (If not institution, gr	ice		41 67 7		2. Date of De Month	29 2006	$5 11:35 P^{M}$
	Exami	ner	-				n, or Location of Dea	ath	4c. County of De	
	Funeral Director	Г		aul Nursing Co Sex 7. Age (In your 1 M 25 F 75	enter s. last birthday) Yrs.	If Under 1 Ye Months Day	ar If Under 24 Hi		ay, Year)	TY irthplace (State or Foreign Country) ryland
	D .		Usual Residence of Decedent					or may	1750 1718	Tyrana
	be filed within 72 hours after deeth with the Maryland hat Hygiene. sd other than "neturel", or Itams 23a or 28a-f show svent, I're Mdical Externing must be notified at	5	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	28a-f	ect	Maryland Allega	3	unt Savag	10f. Zip Code			10- 0%	1 Yes 2 □ No
	3a or	Funeral Director	12810 W	alsh Road, N.W.		21545-			10g. Citizen of What (country?
	deeti	ner	11. Marital Status	12. Was Decedent Ever in		Was Decedent of	of Hispanic Origin? (Specify Yes or No	U.S.A. 14. Race - An	nerican Indian,
9	after or its	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give		_	uban, Mexican, Pue	rto Rican, etc.)	Black, Wh	ite, etc.
21215-0036	hours urel',	d by	3 Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 🕱 N	lo Specify:		Specify: Wh	ite
5-	"net	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a. Dece (Give	dent's Usual Occ kind of work do	cupation ne during most of wi ired)	orking	16b. Kind of Busines	s/Industry
12	should be filed withir of Mental Hygiene. marked other than imatic svent, I've M.	F G	Elementary/Secondary (0-12)	College (1-4or 5+)			ired)			la santan
9	filed Hygid Sther ent, I		12 17. Father's Name (First, Middle, Las	t)	secret	ary / aide	18. Mother's Na	me (First, Middle	senior citizer	's center
an	ild be lental ked ic sv	To Be	Earl L. Walsh				Margaret		, maidon damano,	
Maryland	d 2 should be f th and Mental ! 7 Ie marked of treumatic sve	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stre			er, City or Town, State,	Zip Code)
	5 # 2 T		Debra A. Albright	daughter	17531	Cain Circle	Fro	stburg	Maryland	21532
ore	of of		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 [20b.	Place of Dispo	sition (Name of natory or other p	lace)	Date	20c. Location - City o	
Ĕ	Pa Int:		'4 □ Donation 5 □ Other (Speci	ariomovar nom otato		s Parish Ce		May-2006 1	Mt. Savage N	Maryland
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	Durct	1	. Name and Add Durst Fune		Frost Ave.,	Frostburg, MD	21532
	/Medical Examiner prize and pensage prize and prize transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):	ant	lymp	homa		Onset and Death 3 mently
68760,	ys e	edical E	, t	d						
. Box	death certif e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3□	Ectopic pregnar Other (specify)	осу		23d. Date of de Month	livery Day Year
σ,	The law requires thet the site has been signed by thi page 2 should be detache	by Ph	Part II, Other significant conditions	contributing to death but not re	sulting in the ur	iderlying cause o	given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	quires in sign	d b						1 🗆 Y	es 2 No 3 P	robably 4 Dunknown
Records,	aw requir s been si 2 should	Completed						24a. Was	an 24b. Were a	utopsy findings available
æ	The lay bete has	ШО						autop	med? prior to death?	completion of cause of
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only or		2 MO
o V	d s	Tof	examiner? 1 Yes 2 40	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	3 DOA C			елса 6 ПOther (Spe	cify)
ב	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj			ow injury occurred	,
Si O	Attsnding r death. sctor: After by the funer	cath	2 Accident investigatio	n			Yes 2 □ No			
Division	tel or Atrs after d al Direct ed in by	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre ify)	et, factory, office	3	28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
	To the Hospitel or Attsm within 24 hours after deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medical Exer	nysician: To the best of my kn niner: On the basis of examinated and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	a, and due to the curred at the time, c	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the To the COMP	Σ	29b. Signature and title of certifier	, j			nse number	2	29d. Date signed (Mont	
	2		+. Chotan	M. M.D		05	8853		5/1/6	
	nds		30. Name and address of person who HABIB CHOTANI	131 PENNSY	LVANI	A AVE	, Cum	BERLAN	D, MD.	21502
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 3 2	32. Registrar's Sign.	ature	house				

i			1 - For State Registrar		aryland / Dep			lealth a	and M		Reg. No	06	152	71
	Physic	ian	1. Decedent's Name (First, Middle, La Zumar A. Rauf	st)						2. Date of D	Day	Year	3. Time of	Death
	/Medi Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. Ci	tv. Town. o	r Location o	of Death	04		ZdO6	1:13	J.
4	LXdiiii	ici	WASHINGTO M	EUTIT +	- michal	7	AZO	nA	DINO	V	N	lowing.	SCIMERS	
	Funeral	Photo:	5. Social Security Number 6. S		e (In yrs. last birthda	y) If Uni	der 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi	2,1944	9. Birth	place (State of	r Foreign
-	Director		215-62-4884 Usual Residence of Decedent	A W ZUF	62 Yrs.					April	2,1944	Pak	istan	
	yland		10a. State 10b. County		10c. City, Town or								10d. Inside Cit	ty Limits
	e Mar	ctor	Maryland Montgom	ery	North B	ethe	sda						1 🗌 Yes	2₹ No
	death with the Maryland ma 23a or 28a-f show	ai Director	10e. Street and Number 6352 Windermere C	ircle		10f	Zip Code	20852			10g. Citizen d United			
920	or its	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13		cedent of Hoecify Cuba 2X No	ispanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	0- 14. R B	ace - Ameri lack, White, cify:		ın
Maryland 21215-0036	n 72	Completed	15. Decedent's E. (Specify only highest gra	ide completed)	(Giv	edent's U: e kind of t DO NDT	sual Occup work done o use retired	ation during most	of worki	ng	16b. Kind of	Business/In	ndustry	
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anc	2 should be tiled within and Mental Hygiane. is marked other than *raumatic event, Ir.e Ma.	Be c	17. Father's Name (First, Middle, Last, Abdul	Qayyum				18. Mothe			, Maiden Sum	ame)		
aryl	should nd Me mark imatic	2	19a. Informant's Name/Relationship (19b. Ma	lina Addre	ss (Street a			Begun	er, City or Tow	n State 7in	2 Code)	
	und 2 s elth an 27 is er trau		Sajjid Rauf -son		6850	Dart	mouth	Aver	iue F	Richmon	d, Vir	zinia	23226	į
Baltimore,	permit. Pages 1 and 2 should be tiled within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tree Mange.		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐	Domouni from State	20b. Place of Disp cemetery, cri					ate	20c. Location		own, State	
Ë	Pag tment tent:		4 ☐ Donation 5 ☐ Other (Specify	(r)	George	Washi	.ngtor	ı Cem.	4/2	7/2006	Ade1pł	ni,Mar	yland	
Ba	permit Depar impor any in		21. Signature of Funeral Service) icer	Thom	er .	 00	I Owde	T LITT	T VC	ad ber	al Home tsville	PA Mar	yland20	0705
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Côrevo	in Araze	nter the m		g, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
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687	ticate physis the	edic		. d.					-					
Вох	death certitics attending pt d for use as ti	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth		Tectonic	pregnancy				23d. D	ate of delive	ery	****
o.	The law requires that the death certitic site has been signed by the attending p page 2 should be detached for use as	Physician/Medicai	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		Other (N	lonth	Day Ye	ear
S, D	ires that signed b	by Pi	Part II. Other significant conditions of	ontributing to death bi	ut not resulting in the	underlying	cause give	n in Part I.		23e. Did ti	obacco use co	ntribute to th	ne cause of de	eath?
prd	w require been si should t	ted								10	Yes 2□No	3 Prob	ably 4 Dor	nknown
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alF											rmed?	death? 1 ☐ Yes		
ΖÏ	Physician: this certitics ral director, r	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othe	_		Check only o				
Jol	a = a		27. Manner Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day			28c. Injury Work	4 🔲 INUI:			dence 6 00		()	
Sior	endin sath. or: Att	atio	1 atural 5 Pending 2 Accident investigation		Year) Injury	м		? ′es 2 □ N	0					
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	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Atter completely tilled in by the funer	Medical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination and/or if	th occurre	d at the time n, in my op	e, date and inion, death	place, ar	nd due to the d	cause(s) and m date and place	anner as sta	ated. the cause(s)	
	To th To th c-mpi	Me	29b. Signature and tile of certifier				c. License				29d. Date sign	ed (Month, L	Day, Year)	
	10		1 amidalla	<u>~~</u>	MD		354	27			04-	26-	2006	
			30. Name and address of on who o	completed cause of de	eath (Item 23a) (Type	Print)		WY COL		MKC	04-	200	Mi	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 2	32. Registra	r's Signature	mele	,	1 7		124	7	,	ر	-

			1 - For State Registra Ame	end#18.Per	State of Ma	aryland -3-06	i / Depa icr <i>Ce</i>	artment of I rtificate of	Health Death	and Men		iene 20 (16	1527
4.00	Thereware			e (First, Middle, Last			^			2. [ate of Death	1		3. Time of Death
	Physic /Medi		Moose	evel+			SM	ith	Dr	A	SU /	26 200	ear So	1630 PM
	Examii Funeral		4a. Facility Name (I		topking 7. Age	HOSE e (In yrs. Ia	ital (st birthday)	4b City, Town,	MO (24 Hrs. 8. D	ate of Birth	4c. County of I	. B <u>irthpla</u>	ace (State or Foreign
	Director		420-40-6]M 2□F	68	Yrs.	Months Days	Hours	Min. (/ Ma	y 8	4000	aba	
	land		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation					10	d. Inside City Limits
	Many a-f-sh	tor	MD	Prince	Georges	Lan	ham							1√ Yes 2 No
	ith the	Director	10e. Street and Nur	mber				10f. Zip Code			10	g. Citizen of Wha	t Counti	y?
	ath w		8507 Bra	e Brooke				2070	6		Į	U.S.A.		
5-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ed 2 <mark>⊠</mark> Married 4 □Divorced	12. Was Decedent B Armed Forces? Ŋ☐Yes 2☐N If Yes, Give Year or Dates:	_№ 195		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 ∑No	an, Mexica	n, Puerto Ricar	res or No- n, etc.)	14. Race - A Black, V Specif 2	White, et	tc.
5-(n 72 h	ete	(Ѕрес	15. Decedent's Edu ify only highest grad			16a. Deced (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during mos	st of working	1	6b. Kind of Busin	ess/Indu	istry
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	illed Hygie other	Be C	17. Father's Name ((First, Middle, Last)			Quu.	LOY ASS				aiden Sumame)	enc	
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Maryland	2 sho and I is ma	0	19a. Informant's Na	me/Relationship (Ty	pe, Print)		19b. Mailir	g Address (Street				City or Town, Sta	te, Zip C	code)
	f Health item 27 other tr		Joanna 20a. Method of Disp	M. Smith	1		-		rook		-	n,Md.20		
Baltimore,			1 🖳 Burial 2 [☐Cremation 3 ☐F	lemoval from State	cer	metery, cren	sition (Name of natory or other pla		Date	2012	0c. Location - City		
Ē	그 문문을			5 ☐ Other (Specify) neral Service License	59	MD.		. Cem .		5/4/06 ~		neltenh		MD.
Ä	Depare Impo		Der	ue 2	ewa	de) 39	910 Sil	ver 1	"Hodge H ill R	s and D.Sui	d Edwar	ds Md.	
	Physician /Medical Examiner	ner	23a. Part 1. Enter the foots, or hear Immediate Cause (disease or condition resulting in death) Sequentially list confirming the foots of any, leading to impact the cause. Enter Under Cause (Disease or Lause).	ſ	ne cause on each lin	NIYO	nce of):	Introv	oscu				li C	Approximate nterval Between poset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examin	Cause (Disease or i that initiated events resulting in death) L		Due to (or as a	a conseque	ince of):	mg (av	10 Er			•	3	Months
P.O. Box	law requires that the death certif as been signed by the ettending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal d	eath 3	Ectopic pregnancy Other (specify)	<i>y</i>			23d. Date of Month	delivery Da	ay Year
	w requires that been signed t should be deti	þ	Part II. Dther signifi	cant conditions cor	tributing to death bu	it not result	ing in the ur	derlying cause giv	ren in Part I.	. 2	3e. Did toba	cco use contribute		cause of death?
Division of Vital Records,	The ate h page	Completed									4a. Was an autopsy performe	prior	to comp 1?	y findings available letion of cause of
Z;	Physicien: this certificatal director,	Be	25. Was case referred examiner? 1 ☐ Yes 2 [12]	/	ospital:		T-T-	2□ DOA Oth		of Death (Che				
0		. To	27. Manner of Death	_	1 Vinpatien 28a. Date of Injury	y 2	NOutpatient 8b. Time of	3 □ DOA □ 28c. Injur Wor	4 🗆 140			ce 6 Other (S	pecify)	
ion	Attending Ir death.	atlo	1 ANatural 2 Accident	5 Pending investigation	(Month, Day	Year)	Injury		k? Yes 2∐1			, ,		
ivis		Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At hom . (Specify)	e, farm, stre	et, factory, office		28f. Lo	cation (Stre	et and Number or State)	Rural R	loute Number,
	o the Hospital or Alithin 24 hours after of the Funeral Director the Funeral Director the Funeral Director The Control of the Funeral Director of the Funeral Director of the Funeral Director Office of the Post of the Post		29a. Certifier	19 Certifying Phys	ician: To the hest of	f my knowle	adra dasth	geoured at the time	no data as	d plane and d	- 4- 45			
	Hos Peru	edical	(Check only one)	2 Medical Examin	er: On the basis of and manner state	examinatio	n and/or inv	estigation, in my o	pinion, deal	d place, and du th occurred at t	e to the caus he time, date	se(s) and manner and place, and c	as state	ed. e cause(s)
	To the within 2 To the cumplet	Me	29b. Signature and t	title of certifier	7/4			29c. Licens	e number		29d	. Date signed (Md	onth, Da	y, Year)
•	0111		1 /K	essel	Holes No	dul	Doctor	- RG	25-	000	1	11786	26	12006
2	(b) V	2	and the second s	ss of person who co	mpleted cause of de	ath (Item 2	3a) (Type, F	Print)	220	.1	10 -	Bal	time	12006 re 1 21287
	Sta Registr		31. Date filed (Monti	h, Day, Year) '	22. Registrar	r's Signatus	Lan	Mospital.	,000	North W	He St	rest ma	yler	d 21287
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HAYWA TANARA STRONG 28, APRIL 2006 12:00P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGES CLINTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, DEC. 31, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M XX F Director Yrs. 578 66 1136 56 1949 WASHINGTON, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner near by notified at Director MD PRINCE GEORGES GREENBELT 1XXYes 2 ☐ No 10e, Street and Number 10f. Zio Code 10g. Citizen of What Country? ö or items 23s 6148 SPRINGHILL TERRACE #103 20770 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after XX Never Married 2 Married 1 ☐ Yes XX No II Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No δ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12TH BUS OPERATOR RIDE-ON permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked othe any injury or other traumatic event pixe. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HAYWARD STRONG 2 VIRGIL RUTH COLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NATARA E. STRONG / DAUGHTER 6148 SPRINGHILL TERR. GREENBELT, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State NEWBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) FORT LINCOLN CEMETERY 05/06/2006 BRENTWOOD, MD 21. Signature of Funeral Service Licensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Eugonetrual Concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. Il yes, outcome ol pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date ol delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes XX No 1 Inpatient 2 PER/Outpatient 3□ DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Mannes of Death 28b. Time ol 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide hours after within 24 hours a XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCOTT KELSO, MD 7503 SURRATTS ROAD CLINTON, MD 20735 31. Date filed (Month, Day, Year) MAY 0 3 2006 32. Registrar's Signature State Registrar

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Physicia		Registrar 1. Decedent's Nam	ne (First, Middle,Las			-			2. Date of Deat Month		Year	3. Time of Death
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more, MD 21215-0036 Page 1 and 2 should be filed within 72 hours after death with the Maryland bent of Filed hand Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f show in the Item 17 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1. Never Marr	ied 2 Married	12. Was Decedent Eve Armed Forces?			ecify Cuban, Me		ecify Yes or No- Rican, etc.)	14.	White, etc.	can Indian, Black,
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To To	Me	29b. Signature/ar	nd title of certifier	and manner stated.	$\overline{}$		29c. License nu	umber		29d. Dat	e signed (Mo	nth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 0212 05 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6. Sex ROGIONOS SALLIA Neim 100 PENINSUM CPNY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 182 item 27 is marked other than "natural", or items 23a other traumatic event, its Medical Examinar must to Wad Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced lack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Heelth and Mental H ant: If Item 27 le marked of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ocomi md. 218.51 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Chy or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important: I 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Reword 21. Sign yure of Funeral Service Licensee .O. Bon 33 Pocomoko Mou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Cardiogenni Pnysician /Medical Due to (or as a consequence of): Examiner INTE M sequentially list for ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No annement of Sinm 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? (3) alleralle. 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO ဥ 1 Tes 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide To the Hospitel o within 24 hours of To the Funeral D filled Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

219-67-042

31. Date filed (Month, Day, Year)

32. Pagistrar's Signature MAY 0 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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SHIRE Drive. SALISRIN.

			1 - State Registrar	State of Maryland	•	rtment of H		-	iene g. No. 0) 6	5276
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	Examin	er	Country Meadows	root and ridinosi,		Frede			Frede		
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	iter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give	'	Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		k, White, etc.	
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Baltimore,	permit. Page Depertment Important: if any Injury o		21. Signature of Funeral Service Licen le		22	. Name and Addre	ss of Facility				
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	h		30. Name and address of person who con	mpleted cause of death (Item	23а) (Туре,			Freder		MK 2:	710
	<i></i>	ate	31. Date filed (Month Day Year)	32. Registrar's Signat	mas.	Johnso	N PA	Freder	ruc	1-113 21	102
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	Dhusisi		Decedent's Name (First, Middle, Las	, ,	0.1.	/	2. Date of Death		3. Time of Death
	Physicia /Medic		Charles	HENRY	Stre	eter, JR	April	20 2006	
	Examin	er	4a. Facility Name (If not institution, give	street and number)		Town, or Location of Deat		4c. County of Death	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. k		1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth	Year) 9. Birth	place (State or Foreign
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	yland		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
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}	ms 23	Funeral Director	611 H19h	12. Was Decedent Ever in U.S	S. 13. Was Dece	dent of Hispanic Origin? (S	Specify Yes or No-	14. Race · Ameri	
9	or ite		1 Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No / 9 9 If Yes, Give	1 Yes, spe	cify Cuban, Mexican, Puer 212 No Specify:	to Hican, etc.)	Black, White	, etc.
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and	d be fill and oth	Be c	17. Father's Name (First, Middle, Last)	annell Stra	eter sk	į.	me (First, Middle, M		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Marical Extension and the notified at once.	٩	19a. Informant's Name/Relationship (7			(Street and Number or R			ip Code)
	and 2 salth a n 27 is		Charles A.	Streeter	911 Cent				and 21613
Baltimore,	Pages 1 nent of He ant: If iter ary or oth		20a. Method of Disposition 1 12 Burial 2 Cremation 3	Ce	ace of Disposition (Na emetery, crematory or	other place) i		c. Location - City or T	/ 1
Ħ.	artmen artmen ortent: injury		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen) SM	1 thville (emetery 4/	21/007	aylors Is	land, MD,
Ba	permit. Departr Importe any inju		Danelle C	. Henry	Henry	Address of Facility FuneRal Frashington	St. Camb	iridae M	D. 2/6/3
			23a. Part Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	. Do not enter the mod	te of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between
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9		Medic	To come	· ·					
Вох	death certifica e attending ph id for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic p			23d. Date of deliv	very Day Year
o.	the the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 Cher (s)	pecify)			,
s, P.	s that the ned by e detact	by Ph	Part II. Other significant conditions of	ontributing to death but not resu	alting in the underlying	cause given in Part I.	23e. Did toba	acco use contribute to	the cause of deam?
ords	w requires that been signed b should be deta						1 🗆 Yes	s 2□No 3□Pro	bably 4 Unknown
Record	law as b	ompleted					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
a H	Th ate pag	O	25 W					☑No 1 ☐ Yes	2 □ No
Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3 ☐ Do	Other	ath <i>(Check only one</i> Home 5 ☐ Resider	nce 6 □Other <i>(Speci</i>	ifv)
n of		Ju: T	27. Manual of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe hov		-37
Division	r Attending er death. rector: After by the fune	Certification:	2 Accident investigation		М	1 Yes 2 No	206 1		-10-11
$\overline{\leq}$	or Attencater death	ertifi	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor	y, office	City or Town,	eet and Number or Rur State)	al Houte Number,
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b	alC	29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, death occurred	at the time, date and place	e, and due to the ca	use(s) and manner as:	stated.
	the He in 24 the Fu	fedical	one)	niner: On the basis of examinat and manner stated.					
	To To	Σ	29b. Signature and title of certifier	Her 1	29	L 2 65 8	1 1	d. Date signed (Month,	
			30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	72000		ipril LT,	2006 Ince 21239
_			Stephen G	. Holtzell	M, WD	5601 L	och Ro	wen Bac	Ince 21239
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure K A	d)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23b,25 perME 0856 6/29/06 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26-2006 Cyril Arnold Settles 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) NICOMICO lisbury oasta 20100 6. Sex + tho a If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. October 9,1937 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 MM 2□ F 68 248-58-4445 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 No Fruitland Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21826 USA 107 Autumn Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Air Force Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 M Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Electronic Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Sparks Henry Dewey Settles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107 Autumn Lane, Fruitland, Maryland 21826 Sandra Settles/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cape Charles
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/2/06 Cape Charles, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home P.A. 21. Signature of Funeral Service Licenses 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) intra cerebra Due to (or as a consequence of): Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 28 No 1 ☐ Yes 25KNo 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Invatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at

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Department of Health and Americal Hygie Inportant: If item 27 is marked other than any injury or other freumatic event, ILL 2006.

Physician /Medical

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Certification:

Medical

4 Homicide

31. Date filed (Month, Day, Year)

29a. Certifier

other

by Funeral Directo

Completed

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar 29b

29c. License number

Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

026278 MW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coastel Hospin David E. Carall

32. Registrar's Signature APR 2 8 2006

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06-02879

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Please Type or Print in Black Indelible Ink

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			For State Registrar	State o	f Marylar		artmen rtificat			ınd Me		giene Reg. No.?	106	15280
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2	(10)		30. Name and address of person w	no completed cau	se of death (Ite	m 23a) (Type,	Print)	,	Δ.	, , ,	7	-11 A	11A -	2000
	<u> </u>		31. Date filed (Month, Day, Year)	one	4203	Che	ens	SURI	1 Fd	My	41/00.	,1100	wp 4	2006
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State of Maryland / Department of Health and Mental Hygien P 🛭 🗎 🦰 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** KOBERT 5 ASLAW 25 0338 2006 04 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City Town or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV • 1 , 194 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊈M 2□F Months Yrs. Wash., Director 131-34-8395 59 D.C. Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 17 is marked other then "netural, or items 23s or 28s-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Chester Queen Anne's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Skipper Court 21619 509 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 'TY'es 2 □ No If Yes, Give Year or Dates: 1966–69 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filled within 7 Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "to may rigury or other traumatic event; in a Mad ance. College (1-4or 5+) Elementary/Secondary (0-12) Electronic Retail Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Estelle Myers George Saslaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lee Saslaw / spouse 509 Skipper Ct. Chester, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 05/03/2006 Cheltenham, MD. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. 20715 Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Qo not enter the mode of dying, such as cardiac or respiratory arrest, MIJOCARDIAL Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sete has been signed by the attending physician and page 2 should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 9☐ Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 🗌 No 1 Yes el or Attending Physician: After this certifical funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation nerel Director: A filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month: Day, Year) 29b. Signature and title of certifier arrey 2006 30. Name and atterest of person who completed cause of death (Item 23a) (Type, Print) 6131 EINFELD 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 7 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Oldio of Ma	Ce	rtificate of			3. No.	
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		William	August	us S	owers, J	r.	Month April 2	Day Year 1 2006	11:25 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give :				r Location of Death	APITIZ	4c. County of Dear	
		·	Devlin Manor Hea	alth Care	Center	Cumber	land		Allega	n v
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birt	thplace (State or Foreign
	Director		216-22-6845	t ^{M 2□ F} 7	8 Yrs.	World's Days	Hours Will.	01/08/19		yland
	Du ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	anation.				10d. Inside City Limits
	aryta shov	~			•					1 Ty Yes 2 □ No
	8a-f	Director	MD Alleg	gany	Cumb	erland				A
	vith th	Dir	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23s	Funerai	313 Independent		110	W D d	21502		USA	dana tadina
	er de item	'n		12. Was Decedent E	verin u.s.	If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
36	72 hours after death with the Maryland neturel', or items 23a or 28a-f show Ital Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	1946-	1 ☐ Yes 2 ☐ No	Specify:		Specify:	71 • .
S	e hou		15. Decedent's Edu	cation	16a. Dece	edent's Usual Occup	pation	10	Sb. Kind of Business	White Andustry
Maryland 21215-0036	n "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+	life.	e kind of work done DO NOT use retire	during most of work d)	ing		
212	d with giene ir the	mo:	1.2	4		thodist M	linister		Church	
פ	othe othe	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	aiden Sumame)	
<u>a</u>	uld b Vents rrked rrked	<u>ا</u> ه	William A	ıgustus	Sow	ers, Sr.	Margare	et Pa	uline	Bloss
ar	s ma	ľ	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mail	ing Address (Street	and Number or Run	al Route Number,	City or Town, State, 2	Zip Code)
Σ	and 2 paith 27 i	}	Dorothy E. Sowers	/ wife				et, Cumbe	rland, MD	21502
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other traumatic event. It we deat Examinating must be notified at once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ P	lemoval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac	ce)	Date 20	c. Location - City or	Town, State
Ĕ	Pag nent ant: i		' 4 Donation 5 Other (Specify)		MD Vet.	Cem. @ Ro	cky Gan O	04/24/2	6 Flints	stone. IID
at	Departit. Departit Import eny inj		21. Signature - Funeral Service License	99	2	2. Name and Addre	ss of Facility Ada	ms Famil	y Funeral	Home, P.A.
m	9 9 7 9 9		Kohet C	alcon		404 Decat	ur Street	, Cumber	land, MD	21502
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused t ne cause on each line	he death. Do not er	ter the mode of dyir	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		COP	D				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	LAdillilei	L	Sequentially list conditions, if any, leading to immediate	D						
	ed isit	ine	cause. Enter Underlying	Due to (or as a	consequence of):					
	and and II-trar	Examine	that initiated events resulting in death) Last		consequence of):					
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587	tificate ng phys as the	Medicai		J						
	n certii anding use a		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o					23d. Date of del	iverv
Вох	atte	Physician/	in the past 12 months?	1□Live birth 2 4□Pregnant at t		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i> _	<i>y</i>		Month	Day Year
O.	at the de by the a tached	hys	9 Unknown	9□ Unknown						
٠ <u>,</u>	s that ned t	by P	Part II. Other significent conditions con	ntributing to death but	not resulting in the	underlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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00	aw re	Completed						24a. Was an	24b. Were au	topsy findings available
æ	The la	E O						autopsy performe	ed? death?	completion of cause of
ta		a)	25. Was case referred to medical				26. Place of Deatl	(Check only one)	140 12100	2010
of Vital Records,	Physicien: this certific ral director,	To B	examiner?	lospital: 1 🗌 Inpatien	t 2 ER/Outpatie	nt 3 DOA Oth	ler: 4 💢 Nursing Ho	me 5 Residen	ce 6 □Other (Spe	cify)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (of 28c. Injur		28d. Describe how	injury occurred	
0	Attending r death. ector: After by the fune	atic	2 Accident investigation				Yes 2 □No			
Division	for Attencater death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	ipitel or Al ours after o teral Direc filled in by	Ö					N.			
	To the Hospitel of within 24 hours af To the Funeral D completely filled it	edical	(Check only 2 Medical Exemi	sician: To the best of ner: On the basis of e	examination and/or in					
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner state	90.	29c. Licens	e number	290	I. Date signed (Monti	h. Dav. Year)
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/	IUA		0/-		nub (line 20-) 7				whiii 71	2000
	NAS		30. Name and address of person who co			_	nal Highw	av. LaVa	le. MD 2	1502
	Sta	te	31. Date filed (Month, Day, Year)	32. gistrar	's Signature	4		J ,		
	Registr		APR 2 1 200		- B. A.	made				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Smith Geraldine Frances 22 2006 16:54 APRIL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 XF Director 92 05/23/1913 Maryland 220-10-8759-A Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show ral', or Items 23a or 28a-f show 1 X Yes 2 No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA Marion Street 66 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Wadical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hinp-rtant: If item 27 is marked oth any injury or other traumatic event size. Be Ρ. Wilson Maude Bowman Charles Moscow ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1429 Willow Court, Cumberland, Maryland 21502 Bruce H. Smith / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/26/2006 Rose Hill Cemetery Cumberland, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 elver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** S disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner negative Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2 No 3 Probably 4 □Unknown 1 🗌 Yes Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Impatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 29d. Date signed (Month, Day, Year)

h 3

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2006

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

DHMH 17 Rev 1/2001

Registrar

M.D. 130

32. Registrar's Signature

29c. License number

lvania

			For State Registrar	State of Ma	arylan		artment of tificate o				giene Nog. No.	2006	15284
piere	Physici /Medic Examin	an al	Decedent's Name (First, Middle, La	w. S	he	eare		n, or Location	y	2. Date of Dea Month Pri	2 Cay	Year 2006	3. Time of Death
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9036	72 hours after death with the Maryland "netural", or Itame 23e or 28e-f ehow idical Expresser must be invittled at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 24 Yes 2 1 If Yes, Give Year or Dates:	Ever in U No 194	3-46	Was Decedent of Yes, specify C			ify Yes or No- ican, etc.)		Race - Americ Black, White, pecify: White	etc.
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Maryland	should be filed within of Mental Hygiene. marked other than imatic event, the M	To Be	17. Father's Name (First, Middle, Last Joseph W. Shear	rer, Sr.		105 11-30	Add (C4-	Rosa	aline	First, Middle, Neher			- Co. #1)
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Baltimore,	it. Page: riment o ritent: If njury or	1	1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Lice)	(y)	Met	emetery, crer	matory or other permatory Name and Ad	place)		y H. W	Caton itzke	sville 's Fam:	, MD Lly FH Inc.
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	w requires that the been signed by th should be detache	ted by Ph	Part II. Other significant conditions Congestu	contributing to death b	ut not res	ulting in the u	pderlying cause	given in Part	1.	23e. Did to	1	1	he cause of death?
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	To the Hospital or Attendi within 24 hours after death. To tha Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examina	owledge, deat ation and/or in	n occurred at the	e time, date a ny opinion, de	nd place, ar ath occurred	nd due to the o	ause(s) ar	nd manner as s lace, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	M			29c. Lic	ense number	70		April April	signed (Month,	Day, Year) U2006
(O)	}		30 Name and address of person who	completed cause of c	leath (Iter	n 23a) (Type,	Bell 1	Lænl	Cl	acks	all	2 MD	200Ce 21029
	Sta Regista		31. Date filed (Month, Day, Year) MAY 0 1	2006 32. Registr	ar's Signa	ature &	bartes						

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-	/Medic		RENEE		3/1701	4b. City, Tow		a of Dooth	April	aa	County of D		10100
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			THE JOHNS HOPKINS 5. Social Security Number 6. Sec		n yrs. last birthday)	BALTIN If Under 1 Y		er 24 Hrs.	8. Date of Birt	·h	0	Disthelace /S	State or Foreign
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	land		10a. State 10b. County	10	c. City, Town or Lo	ocation						10d. Ins	ide City Limits
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<u>=</u>	mit.		21. Signature of Fyneral Service Licens	99	2:	2. Name and A	ddress of Fa	cility	-				
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	that the death cert ed by the attendin detached for use	icia Bi	in the past 12 months? 1 ☐ Yes 2 💢 No	4 Pregnant at tim		□Ectopic pregn □ Other (s <i>pecif</i>					Month	Day	Year
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\(\bar{\sigma}\)	ysician: The la is certificete hes director, page 2	m	examiner?	Hospital: 1 X Inpatient	2 ER/Outpatie	nt 3 DOA	Othor		me 5□Resi		6 □Other /	Snecity)	
ō	Physic rethis seal di	To To	27. Manner of Death	28a. Date of Injury	28b. Time o		Injury at Work?		28d. Describe			эросну	
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	spite		29a. Certifier 1 Certifying Phy	rsicien: To the best of r	my knowledge, deal	th occurred at t	he time, date	and place,	and due to the	cause(s)	and manne	r as stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Medical		iner: On the basis of ex and manner state	camination and/or in								ause(s)
	roth within ompl	Me	29b. Signature and title of certifier				cense numbe			29d. Dat	te signed (M	lonth, Day, Y	'ear)
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			30. Name and address of person who o	ompleted cause of dea	th (Item 23a) (Type	Print)							21281
-	NR4		MONIKA RURNESS . T	HE JOHNS H	HOPKINS HI	SPITAL	. 600 NO	RTH W	OLFE STI	REET	BALTIN	MORE, M	ARYLAND
100	Sta	ite	MONIKA BURNESS, 7 31. Date filed (Month, Day, Year) APR 2 8	32. Figistrar's	Signature	1 10	, 000		/ /	,	-		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 26, Day 2006 **Physician** 8:15AM Simmons Geneva A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Aberdeen Harford 606 Market Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8/22/1932 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F 73 213-30-6325 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "netural", or items 23s or 28s-1 show other traumatic event. The Medical Examinar must be notified at 1 XYes 2 ☐ No Directo MD Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 U.S.A. 606 Market Street death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "netural" or 27 ie marked other than "netural" or 2005. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 277 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 200 No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) In home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sally Bell Crouse James Leonard Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen, Maryland 21001 Clayton Simmons (Spouse) 606 Market St., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4/28/06 Aberdeen, Maryland Baker Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 3a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic obstructive pulmonery Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Cther (specify) n signed by the a ld be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown been sig osteoporosis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an actic regurgitation certificate has b irector, page 2 sl autopsy 1 Yes 2 No 1 Yes 2 No Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 2× No 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □ Other (Specify) 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Algorithms of the funeral Director of completely filled in by the fu 1 Tes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 4/27/06 000049050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #400 therdeen mD 21001 Shukla, M.D. 15 South Parke Street Prashant 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 2 7 2006

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** SYLVIA ZELDA SAPOSNEKOO APRIL 25**,** 2006 1:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MANOR CARE POTOMAC MONTGOMERY If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 T F Yrs. Director 577-10-3836 88 15, 1917 NEW YORK Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral, or items 23a or 28a-f show Executor must be notified at 1 X Yes 2 □ No FLORIDA BROWARD DEERFIELD BEACH Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2040 LYNDHURST J. 33442 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then Efementary/Secondary (0-12) College (1-4or 5+) IDA'S DEPARTMENT STORE 12 BOOKKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Itam 27 is marked oth any injury or puther treumatic event 2002. Be NATHAN RASSIN ROSE FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILIP R. MILLER/SON IN LAW 7608 GLACKENS DR, POTOMAC, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEML GDNS 04/27/2006 FALLS CHURCH, VIRGINIA 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 21. Signature of Funeral Service Licenses INC. Ustileneer onald. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or compfications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Cere disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence The law requires that the death certificate be executed the burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as aftending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 W No 9 ☐ Unknown the 9☐ Unknown hed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be c 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 2 10 No 1 Yes 1 ☐ Yes 2 No Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Matural 2 Accident 5 Pending 1 Tes 2 No death. investigation after deat filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 To the Hospital within 24 hours a To the Funeral C **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certifier D0057124 MO E) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TROUNG BAO, 13219 EXECUTIVE PARK TERRACE, GERMANTOWN, MARYLAND 31. Date filed (Month, Day, Year) APR 2 8 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1212 PM 30 2006 Dril ALBERT LEROY SINES /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□ F Yrs. 215-26-7983 85 Director MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State work! r then "natural", or frams 23a or 28a-f showing the Medical Examinar must be notified at 1XYes 2 No Director **BOONSBORO** MARYLAND WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 U.S.A. 141 SOUTH MAIN STREET 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify 3 Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STATE GOVERNMENT MAINTENANCE rmit. Pages 1 and 2 should be filed w partment of Health and Mental Hygien portant: If Item 27 Is marked other tl y injury or other traumatic event, ID. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EVA HOUPT HARRY SINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 6037 APPLETOWN ROAD, BOONSBORO, MARYLAND RICHARD W. SINES/SON Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or soce. 4 ☐ Donation 5 ☐ Other (Specify) ZION LUTHERAN CEMETERY 05/04/2006 MIDDLETOWN, MARYLAND 21. Sign ture of Funer I Service Livensee 7606 Old National Pike BAST FUNERAL HOME Paul m. Dean Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical hum Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No 1 ☐ Yes Division of Vital or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after decreal Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Guedenet Willand 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

		for State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of rtificate o			giene (06	15289
Tage 11 ha		1. Decedent's Name (First, Middle, La	ast)				2. Date of De	ath	Varia	3. Time of Death
Physicia /Medic		Charles Seym	ore Taylor				April	29	2006	11:48Р м
Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town	, or Location of De	eath	4c. County	of Death	
		528 Guilford Av	enue			erstown		Wash	ingto	n County
Funeral			Sex 7. Age 1 XM 2 ☐ F	(In yrs. last birthday)	If Under 1 Year Months Day		Hrs. 8. Date of Bird (Month, Da	h y, Yea <i>r</i>)	9. Birthpl	ace (State or Foreign
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and	ľ	10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits
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t Head		20a. Method of Disposition	TOWC (SIBCC	20b. Place of Dispo	sition (Name of		Date	20c. Location -		
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mit. F oartm oorter Injui		21. Signature of Funeral Service Lice					Douglas A		_	_
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n: Tr licete r. pag	10.00		_				1 ☐ Yes			2□No
sicial certii recto	Be	25. Was case referred to medical examiner?	Hospital:		10		Death Check only o			
ral di	5	1 Yes 2 No 27. Manner of Teath	1 L Inpatien		t 3 DOA	Other: 4 Nursing	g Home 5 Resident	ence 6 Oth)
ding Afte	to	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	W	ork? □Yes 2□No	200. Describe i	injury occur	90	
Attending Physician: The laver of the favored physician of the favored physician and factor. After this certificate has by the funeral director, page 2	flca	3 ☐ Suicide 6 ☐ Could not I	be 200 Close of Injur	ry - At home, farm, str			28f. Location (5	Street and Numb	er or Rural	Route Number
d is b	Certification;	4 Homicide	building, etc.	(Specify)		7	City or Tox	m, State)	0, 0, 1, 1, 1, 1, 1	riodic Namber,
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours elter death. To the Funeric Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 ertifyin P	hysician: To the best of	f my knowledge, deat	h occurred at the	time, date and of	and dual other	sause(s) and nic	without also site	it5d.
ne Hc n 24 l ne Fu stetel)	edical	(Check only 2 Medical Exa	miner: On the basis of and manner state	examination and/or in	vestigation, in my	y opinion, death or	ccurred at the time,	date and place,	and due to	the cause(s)
To the To the comp	ž	29b. Signature and title of certifier		1	29c. Lice	nse number		29d. Date signe	d (Month, C	Day, Year)
		Hall	Den	don 1	()()	1464	73	MON	01	. 200L
		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)	200 0	- 11	111019	,	DIM -
H-4+1		Hind Hama	Jan, M	1); 113	00	PAL	1: 46	gers	town	, 2006 , m) 21740
Sta		31. Date filed (Month, Day, Year)	32. Registrar	r's Signature				V		
Registra	ar	MAY 0 2 20	106 Baran	. A. Don	uses					

			1 - State Registrar	,	epartment of He Certificate of D	ealth and Mental H eath	lygiene 0 0 6	15290
	Physicia		1 Decedent's Name (First Middle Last)	TOLZMY	AN	2. Date of Month		
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street and 418 Highland Drive 5. Social Security Number 6. Sex 1 M 25 Usual Residence of Decedent	7. Age (In yrs. last birth	4b. City, Town, or L Edgewa If Under 1 Year Months Days	ter If Under 24 Hrs. B. Date of (Month,		
	death with the Maryland ims 23a or 28a-f show	ž	10a. State 10b. County Maryland Anne Arundel	10c. City, Town	or Location rewater			10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	r 28a-f	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	Country?
	ath with	raiD	418 Highland Drive		210		German	
036	urs after de: al', or Items	by Funerai	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. es XIX No , Give or Dates:	13. Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No	panic Origin? (Specify Yes or Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Am Black, Wh Specify: W	nite, etc.
21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or liems 23a or 28a-f show aumatic event, it a Madical East litter must be inclifted at	Completed		ge (1-4or 5+)	Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)		16b. Kind of Busines Beauty	s/Industry Salon
Q	be filed hal Hygie od other	0	17. Father's Name (First, Middle, Last)		airstylist	18. Mother's Name (First, Mid		
Maryland	ould be Menta Parked Parked	To B	Heinrich Krings	10		Katarina Scha		Zin Codel
Mar	nd 2 sh Ith and 27 is rr traurr		19a Informant's Name/Relationship (Type, Print) Frederick A. Farber (S			b Dr. Montcla		
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fit 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemetery	Disposition (Name of y, crematory or other place, Crematory	Date	20c. Location · City of Edgewater,	or Town, State
Balt	permit. Departr imports any inje		21. Signature 17-uneral Service Licensee	_		of Facility George Ins Island Rd.		
8260, %	Physician / Medical bullian and physician and physician and physician and street in the purian items it	ai Examiner	S-quentially list conditions. f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of	in heart ferrion	such as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death 3
P.O. Box 687	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medicai	in the past 12 months?	, outcome of pregnancy ive birth 2 □ Fetal death regnant at time of death Inknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of d Month	lelivery Day Year
	gned by be deta	by Ph	Part fl. Other significant conditions contributing	to death but not resulting in	the underlying cause give		id tobacco use contribute	
Vital Records,	w requir been si should I	eted	ny per newoma	-, Ihom	ver Type			Probably 4 □Unknown autopsy findings available
Rec	fhe taw te has age 2 s	Completed				a	utopsy prior to erformed2 death	o completion of cause of
/ital	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner? Hospital:		tration 35 DOA Other	26. Place of Death (Check or	nly one)	AUGHTER'S
Division of	Jing Afte fune	ation: To	27. Manner of Death 28a. D		Time of 28c. Injury Nork	4 Nursing Home 3 7	Residence 6 Other (Spines (Spi	MONTS I DENCE
Divis	al or Atters after des	Certification:	3 Suicide 6 Could not be determined 28e. F	Pface of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		on (Street and Number or Town, State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical ((Check only Medical Examiner: On t			e, date and place, and due to inion, death occurred at the ti		
	Withi To th	M	29b. Signature and title of certifier	en Aa m	29c. License	number 2 1 BS	29d. Date signed (Mo	nth, Day, Year)
	5		36 Name and address of person who completed	cause of death (ftern 23a)	(Type Pript)	KE Lich	AN ANNO	ous Morres
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 5 2006	32. Registrar's Signature	ouls!	-30 / 1	1	- V

	•	1 - For State Registrar	State of Maryland	,	artment of F		-	giene Reg. No	2006	15	29
Physici		Decedent's Name (First, Middle, Last) Jessie Eugene	Tucker				2. Date of De Month 04	Day 27	Year 06	3. Time of 7:21	
/Medi Examir	-	4a. Facility Name (If not institution, give s. Fort Washington H.	treet and number)			ashingto	on		county of Death	h	
Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ıy, Year)	9. Birtl Co VA	hplace (State ountry)	or Foreig
Maryland -f show	tor	10a. State 10b. County MD Prince G		rt Wa	shington					10d. Inside Ci	•
with the a or 28s Lbe not	Director	10e. Street and Number			10f. Zip Code	,			en of What Co		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event. The Medical Examinar must be notified at sonce.	by Funeral	1716 Rhodesia Ave 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.: Armed Forces? 1 Syes 2 □ No If Yes, Give Year or Dates: 169-1		2074 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin?	(Specify Yes or No ento Rican, etc.))- 1	nited S 4. Race - Ame Black, White Specify: B1	rican Indian, e, etc.	
ithin 72 hou ne. han "natura e Medical E	Completed 1	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of w	vorking		d of Business/		
d be filed wantal Hygier ced other the cevent, the	Be	12 17. Father's Name (First, Middle, Last) Charles J. Tucker	. 4	Pos	tal Clerk		ame (First, Middle		eral Go Gumame)	vernme	nt_
2 shoul and Me is mark	P	19a. Informant's Name/Relationship (Typ	oe, Print)	1	ng Address (Street	and Number or i	Rural Route Numb				_
ages 1 and nt of Health : If item 27 or other tr		Arlene L. Tucker/ 20a. Method of Disposition 1\(\mathbb{X}\) Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{R}\)	emoval from State	lace of Dispo emetery, cre	Rhodesia sition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or	Town, State	4
permit. Pa Departmer Important eny injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		/ 2	ans Cemet 2. Name and Addre 500 Allen	ss of Facility S	trickland	l Fune		rvices	
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Security flat on thin a fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e cause on each line. AThe Rosc Due to (or as a consequ	lex of):	fic (an	-			_se	Approximat Interval Bet Onset and I	tween
The law requires that the death certificate be executed to be been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence of pregnarm 1	ncy death 3[□Ectopic pregnancy			23	d. Date of deli Month		Year
es that the de igned by the be detached	by Physi	1 Yes 2 No 9 Unknown Part II. Other significent conditions con	9□ Unknown			en in Part I.	23e. Did t	obacco us	e contribute to	the cause of d	death?
e law require hes been sig je 2 should b	Completed b						24a. Was		24b. Were au		
iiclan: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?		· · · · · ·		26. Place of D	1 Yes	2 ∕ ⊠ No	1 ☐ Yes	2 🔀 No	
ding Phys h. After this funeral di	ည	1 Yes 25 No H	ospital: 1 ☐ Inpatient 2 ☒ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	4 Nulsing	Home 5 Resi			afy)	
	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify				28f. Location (City or To	Street and wn, State)	Number or Ru	rai Route Num	ıber,
ne Hospitel or Al n 24 hours after o ne Funeral Direct Metely filled in by	edicai	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s	5)
To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Manth	Day, Year)	6
JC St	ate	30. Name and address of person who con MicHAEL Sida (Month, Day, Year) MAY 1 2006	mpleted cause of death (Item 32. Registrar's Signal	23a) (Type,	Print)	RU#	10/, ff h	rash,	ing for	M 02	.75

		-	For State Registrer	State of Ma	•	epartme Certifica			nd Me		giene Neg. No	006	152	92
	Physicia		1. Decedent's Name (First, Middle, Last)							Date of Dea	th Day	2006	3. Time of	
*	/Medic	al -	Mary J. Thompson 4a. Facility Name (If not institution, give s	treet and number)		4b. City	. Town, or	Location of		pril		Sounty of Death	5:00	рм
	Examin	er	Heartland Healthca		ville	1 1	ttsvi		Dout			nce Geo		
	Funeral Director		3//-32-3600	7. Age	(In yrs. last birth	if Under Months	or 1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day ept.]	, Year) 10,19	9. Birthe Could 10 Sout	olace (State o ntry) h Caro	r Foreign lina
	land ow	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside Ci	ty Limits
	a-fsh	ctor	DC		Washing	gton							1 🛣 Yes	2 🗆 No
	vith th	Funeral Director	10e. Street and Number				ip Code					en of What Cou	ntry?	
	eath v	eral	1008 Monroe Stree	t NW apt 12. Was Decedent E			0010 edent of His	spanic Orig	in? (Specif	ly Yes or No-	US 14	A I. Race - Americ	can Indian,	
9	filed within 72 hours after death with the Maryland Hygiene. Hygiene natural, or Items 23e or 28e-f show ant, the Medical Evantiner must be notified at	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 N If Yes, Give		13. Was Dec If Yes, sp 1 ☐ Yes		Nexican, Specify:	, Puerto Rio	can, etc.)	- 1	Black, White,		
003	ural', c	d by	3 XWidowed 4 □ Divorced	Year or Dates:	10-							Specify: Bla		
21215-0036	in 72 t	Completed	15, Decedent's Educ (Specify only highest grade	completed)		Decedent's Us (Give kind of w life. DO NOT	ork done d	uring most	of working		16D. KING	d of Business/In	idustry	
212	filed withi Hygiene. other than	Som	Elementary/Secondary (0-12) 6th	College (1-4or 5-	F) H	lousewi	fe				Pr	ivate		
pu	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)							First, Middle, Stersor		umame)		
Maryland	should be nd Mental marked umatic ev	٦	Benjamin Thomas 19a, Informant's Name/Relationship (Ty,	pe. Print)	19b.	Mailing Addres	ss (Street a					Town, State, Zip	Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene I Health and Mental Hyglene I Health and Mental Hyglene I Health and I I I I I I I I I I I I I I I I I I I		Francine Burton/									C 20010		
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of cemetery	Disposition (No. 1), crematory or	ame of other place		Dat			ation - City or To		
tim	Pages tment of I tant: If it		*4 □Donation 5 □ Other (Specify)		Glenwo	od Cem		- 1	9/06			ington,		II
Bal	permit. Pages Department of Important: If any injury or once.		21. Signature of Juneral Service License	Shert	-	716 K	enned	y Str	eet N	W Wash	ningt	kins Fu on, DC		
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	ners Dem	entia f):							Interval Bett Onset and I	ween Death
ox 68760,	death certificate be executed to attending physician and ad for use as the burial-transit	/Medical Examiner	resulting in death) Last	Due to (or as a	consequence of	f):					23	d. Date of deliv	erv	
O. B	that the death ed by the atten detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 200000 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (Month		Year .
rds, P.	sign d be	by	Part II. Other significant conditions con Hyperte		t not resulting in	the underlying	cause give	in in Part I.			obacco uso es 2	e contribute to t		leath? Jnknown
I Records,	The ate h	Completed										24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings and properties of careful and the careful and th	available ause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:			Othe			Check only o				
of	ding Phys h. After this funeral di	ıtlon; To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Day	1.5		28c. Injury Work	4/1_Myur	28	5 ☐ Resident d. Describe h		Other (Special occurred	fy)	
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	Iry - At home, far :. (Specify)	m, street, facto	ory, office		28	f. Location (S City or Tow	Street and vn, State)	Number or Run	al Route Num	ber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier 1∑ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and	, death occurre Vor investigation	d at the tim on, in my op	e, date and pinion, deat	d place, an th occurred	d due to the d at the time, d	cause(s) a date and p	ind manner as s place, and due t	stated. o the cause(s)
	To the H within 24 To the For	Me	29b. Signature and title of certifier				9c. License		0.0		29d. Date	signed (Month,		
	(2)		90	uly	myself.	-	Dog	820	290		7	11001	06	
R	(3)		30. Name and address of person who co Sureshkumar Mutta			Type, Print) Queensl	oury l	Rd., 1	Hyatt	sville	Md.	20781		
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 1 2006	Registra	ur's Signature	•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 11:04 Apr **Physician** 1,797 23 2000 Inomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Glacks Spellman Nursing Hom.

5. Social Security Number 6. Sex 7. Age (In vrs last birthday) 9. Birthplace (State of Foreign Country) St birthday) If Under 1 Year | If Under 24 Hrs. Chevern 8. Date of Birth (Month, Day, Year) **Funeral** 63 1 MM 2□F 62 153 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f ehow traumatic event, the Medical Examinment by notified at DC 1 Yes 2 □ No Director DC WASH. 10g. Citizen of Whal Country? 10e, Street and Number 10f. Zip Code NE USA 20017 1636 Funerai filed within 72 hours after death iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) reasury al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit tment of Health and Mental H tant: if item 27 Is marked off Mitchel Johnson Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3612 Peartree Natalie Thomas Dau. or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Depertment of Important: ff any injury or gnose. 5-6-06 Landover Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) T RHINES JOHN 22. Name and Address of Facility 21. Signature of Funeral Service Dicen ee Lecen 3015-12th STNE WASH DC 20017 Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 6 months **Physician** ongestive Heart
Due to (outs a consequence of): disease or condition resulting in death) Failure /Medical Examiner MI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the use as i IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Dale of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 1 ☐ Yes 2 🗷 No O 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mell 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Failur 1 ☐ Yes 2 No Division of Vital To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, streel, factory, office building, etc. (Specify) 4 Homicide hours after 20 To the Hospital o within 24 hours aft To the Funeral Di 1 Scertifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifier (Check on 29b. Signature and title of certifier 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

Registrar's Signature

urthe

Revolthy M 31. Date filed (Month, Day, Year)

MAY 0 1 2006

Landover Rd. Chevery

06-02805 Matthew Twigg

Please Type or Print in Black Indelible Ink of Maryland / Department of Health and Mental Hy

attiic	∋w ı	wigg		State Of 1-For State Registrar	Maryland / Depan Certi	ificate of D		ia ivientai	-	eg. No. 200	6 1529
ledio		nysicia Exami	an/	Decedent's Name (First, Middle, Last)					2. Date of Deat Month April 25, 2		3 Time of Death 1309 hrs
-	Ju			Matthew Twigg 4a. Facility Name (if not institution, give s	reet and number)	1	•	r Location of De		4c. County of Deat	h
	Fu	neral		9167 Victoria Drive 5. Social Security Number 6. Sex	7. Age (In yrs. lasi		Ilicott City f Under 1 Ye		Hrs. 8 Date of Bird	Howard th(MM/DD/YYYY) 9. Bi	rthplace (State or
		ector			2_F 24	Yrs.	Months Day	ys Hours N	03/30/	1982 Forei	gn puntry Mar yland
		any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	<u>-</u>				10d. Inside City Limits
	yland	28a-f show	ţ	MD Howard 10e. Street and Number	E	llicott	City Of. Zip Code		Lac	og. Citizen of What Cou	1 Yes 2 No
	the Mar	sa or 28a etified at	Director	9167 Victoria Dr	rive			042	'	USA	
	and 2 should be filed within 72 hours after death with the Maryland	items 2.3 ust be no	Funeral	11. Marital Status 1 X Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? Yes 2 X No			ispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	- 14. Race - Amer White, etc.	rican Indian, Black,
	rs after d	ıral", or miner m	<u>ā</u>	3 Widowed 4 Divorced If	Yes, Give Year Dates:	1 Ye	s 2 X N		of work done	Specify: Wh.	ite
g	n 72 hou	ntal Hygiene rked other than "natural" ent, the Medical Examine	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most		e. DO NOT use i		Plumbing/H	
215,0036	led withi	lygiene other than the Medical	Com	17. Father's Name (First, Middle, Last)				18.Mother's Na	me (First, Middle, M		V11C
2424	Jd be fil	Mental I marked event,	To Be	Robert L. Twigg 19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing Ad	Idress (Stre	Debra		nber, City or Town, State	e, Zip Code)
2	od 2 sho	nt of Health and Me t: If item 27 is man other traumatic ev		Debra Giles/moth		9167 V			Ellicott	City, MD	21042
2	ages la	ant of He nt: If ite		1 X Burial 2 Cremation 3	Removal from State Cre	ematory or other	place)		/29/2006		sville, MD
Dolltimore	Daller vermit. P	Department of Health and Mental Hygene Important: If item 27 is marked other it injury or other traumatic event, the Med		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	M01442					itzke's Far licott Cit	nily FH Inc. y, MD 21043
ŀ	hys	ician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each	ations that caused the death. D		_			-	Approximate Interval Between Onset and
		edical miner		Immediate Cause (Final disease a. \underline{Fe}	entanyl intoxicat e to (or as a consequence of):	ion				70	Death
			ē	Sequentially list conditions, if any, leading to immediate Du	e to (or as a consequence of):						
			Examine	cause Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence of):					-	
	ecuted	and - transit	al Ex	d	100 1	DTT 07 00	C 1	- OFF F	117 /oc mm		
9	ate be ex	physician he burial -	Medical		AMENDED item #23a, l		-i,pen	E,g855,5/	1//06 TT	23d. Date of deliver	y
	BOX 66 / e death certific	the attending pred for use as th	Physician/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of deat	2 Fetal	death 3 (Specify)	Ectopic pre	gnancy	Month	Day Year
	the deat	by the att ached for	Physi	Part II. Other significant conditions	9 Unknown			given in Part I	23e. Did to	obacco use contribute to	the cause of death?
0	ires that	signed be det	d by	Cocaine and narcoti					1Yes	2 No 3 Pro	bably 4 🗸 Unknown
7	SOFOS law requ	has been a	Completed						24a Was autop		utopsy findings available completion of cause of
0	= Ke	this certificate I	e Con	25. Was case referred to medical			26.Plac	ce of Death (Che	1 Yes	2 No 1 Y	es 2 No
7,7,6	r VICE Physicia	r this ce	To B	examiner? 1 Yes 2 No 27. Manner of Death		R/Outpatient 3	L-comit	Other Nu		Residence 6 Othe	r: Scene
!	ON O	eath Ior: After tl the funeral	ition:	1 Natural 5 Pending	(Month, Day,Year)	unk		Yes 2 No	unk	now injury occurred	
	DIVISION OF VITAL RECOFGS, tal or Attending Physician: The law requir	ours after de reral Direct filled in by	ertification:	3 Suicide 6 XX Could not be	28e. Place of Injury - At hom (Specify) found at 1	ne, farm, street, f	actory, office	building, etc.	28f. Location (Some Town, Some Ellitcott	tate) 0167 Victo	ural Route Number, City Pria Dr.
	UIVISION OF VITAL RECORDS, P.O. BOX 66/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death To the Funeral Director: completely filled in by the	ပ		: To the best of my knowledge in the basis of examination and	e, death occurred			and due to the caus	e(s) and manner as sta	
	To th	within To th comp	Medical	29b. Signature and title of certifier	nd manner stated			nse number	dat the time, date	29d. Date signed (Mo	
				hig hi, 1			0.0	C.M.E.		April 26, 2006	
(e)				30. Name and address of person who con Ling Li, MD Assistant Med	npleted cause of death (Item 2 dical Examiner 111 F		Baltimore	, MD 21201			
		s	tate	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	H do	N.				

		•	For State Registrar	State of Ma	aryland / [Department of F Certificate of I			ene 2006	15295
Н			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Charles Robert Th						28 2006	4:50 a ^M
<i>F.</i>	Examin Funeral Director		4a. Facility Name (If not institution, give s Westminster Nursir 5. Social Security Number 212-20-7334 6. Sev	ng and Coi	(In yrs. last bii	ent West	r Location of Death minster If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birth	roll place (State or Foreign ntry) MD
	ס		Usual Residence of Decedent					May 21	1925	
	enylan ehow	٦	MD 10b. County Carro	11	10c. City, Tow	m or Location Westminster				10d, Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	MD Carro. 10e. Street and Number	L <u>T</u>		10f. Zip Code		100	g. Citizen of What Cou	
	3a or	J Dir	30 Locust Street	t Apt 1	04		21157		USA	,
215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. Hygiene. marked other than "naturel", or items 23a or 28a-f ehow marked other than "naturel", or items 23a or 28a-f ehow marke orent, tra Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent I Armed Forces? 1 TYes 2 IN If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
က်	72 ho natur dicel	eted	15. Decedent's Edu (Specify only highest grade		16a	Decedent's Usual Occup (Give kind of work done	during most of work	ing 16	Bb. Kind of Business/Ir	ndustry
127	within then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT use retired Salesma			Sales	
ם	ouid be filed v Mentat Hygie arked other atic event, It	To Be Co	17. Father's Name (First, Middle, Last) George Dewey					e (First, Middle, Ma Lha Smith		
ary	es 1 and 2 should b of Health and Ment I Item 27 le marked r other treumatice		19a. Informant's Name/Relationship (Ty	pe, Print)		b. Mailing Address (Street			-	
	and 2 ealth m 27 i		Robin Spivey/daught	ter		2108 CLopper		Finksbur		
ore e	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ P	lemoval from State	I .	of Disposition (Name of ry, crematory or other place			c. Location - City or T	
altimore,	pernit. Pages Department of Important: If I any njury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	2 0	Meado	w Branch Cen	+,	1/2006	Westminst	
B	Pen Impo		John K 1	all					apel, P.A.	
-	Physician		23a. Park Enter the disease, or complishock, or heart lailure. List only or Immediate Cause (Final disease or condition	ne cause on each lir	10.	not enter the mode of dying	ng, such as cardiac	or respiratory arres	inster, M	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):				
		-	If any leading to immediate	Due to for as	a conse uence	eme-				4/3
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	may 1	المناطب	·~				25 91.
o,	e exec ien an urial-tr	Exa	resulting in death) Last	Due to (or s	a consequence	of):			Į.	
8760,	ficate be executed physicien and is the burial-transit	dicai		i					-	
	ath certi ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	<i>(</i>		23d. Date of deliv Month	rery Day Year
<u>.</u>	uires thet the dei signed by the a Id be detached f	y Ph	Part II. Other significant conditions cor	ntributing to death b	ut not resulting	in the underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires been sign should be	ed by	Cereppol von	cula o	reed	ent		1 🗆 Yes	2□No 3□Pro	babiy 4 Dunknown
Division of Vital Records,	The law reate has bee bage 2 sho	Completed						24a. Was an autopsy performe	24b. Were autoprior to condeath?	opsy lindings available ompletion of cause of
/ita	ertifica ector.	Be	25. Was case referred to medical examiner?	1				h (Check only one)		
5	Physic this c	<u>۲</u>	1 Yes 2 No	lospital: 1 Inpatie		The second secon	Thursing Ho	me 5 Residen	ce 6 Other (Special	fy)
O	ding th. After funer	tion	1 atural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Da)	y Year)	Injury Wor	k? Yes 2 □ No	200. Describe flow	rinjury occurred	
Divisi	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, la c. <i>(Specity)</i>	arm, street, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	Hospit 24 hours Funera etely fille	edicai C	29a. Certifier 11 Certifying Physical Control (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination at	e, death/occurred at the ti- nd/or investigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and marmer as e and place, and due	o the cause(s)
	To the vithin To the Comple	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
	11			\mathcal{I}	-1	DOC	25076.	3	4/28/0	0
	MZ	- 1	30. Name and address of person with 12	este Mend	2.0 1	(Type, Print)	11.60			
			31. Date liled (Month, Day, Year)	32. Regittr	ar's Signature	CE VIVO 2	1157			
*	Sta Regist				eus E	South				

06-03043 Christine Taffe Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			(Certifica	ate of	Death					Reg. No	. 2	0.0	6	1520
Physicia ledical Exami	an/	1. Decedent's Name (F Christi	ne M.	Taaffe								Date of Do Month May 5, 2	Day 2006		ar	3. Time o	
		4a. Facility Name (if no Suburban Hos		, give street and n	ımber)		4	o. City, Too Bethes		ocation of	Death	_	1	lc. County of Montgon			
Funeral Director		5. Social Security Num 477-94-97	160	6. Sex	7. Age (In y	yrs. last birth 27	nday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of I	,	иддуүүү 1978	Foreign	n	MN .
nd ihow any <u>ce.</u>	_		ecedent b. County Montg	omerv	10c.	City, Town o							-,-				de City Limits
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 3916 East	er				<i>y</i>	10f. Zip C	ode 815					itizen of Wr		•	
or items	by Funeral	11. Marital Status 1 XNever Married 3 Widowed		12. Was Derried Armed F 1 Yes rced If Yes, Give Ye or Dates:	2 X N		If Ye	Decedent s, specify Yes 2	Cuban,	Mexican, F		cify Yes or can, etc.)	No-		e, etc.	can Indian	, Black,
036 Ithin 72 hours aftene. ne. r than "natural", ledical Examiner	Completed t	15. Decedent's Educ Elementary/Second			de complete 1-4 or 5+)		luring mo	s Usual Oo st of workii am Ma	ng life. I	DO NOT u				Kind of Bu			
nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Health and Mental Hygiene. It: If item 27 is marked other than other traumatic event, the Medical	Be Co	17. Father's Name (Fit Richard T	aaffe							Jea	ın Ma	tthie	28	n Surname	1		
MD 21 d 2 should lth and Mer n 27 is man	To	19a. Informant's Name Richard D	. Taa			9	Par	kway	Sil	ver C	reek	, NY	Number, City or Town, State, Zip Code) 14136 20c. Location - City or Town, State				
1		20a. Method of Dispos 1 Burial 2 X 4 Donation 5	Cremation Other Spe	ecify:			ory or other	er place) Crem	ato	ry	May		006F	alls (Chur	ch,	
Physician Physician Physician		21. Signature of Funeral Service Licensee William R. Buggs Per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock failure. List only one cause on each line.							ingto	n, D	C 20	016					
/Medical			one cause on al disease				1		-,3,							Betwee	en Onset and Death
L	ner	Sequentially list condi if any, leading to imme cause. Enter Underly	ediate	Due to (or as	OCOCCUS a consequen		oniae					<u>-</u>					
ecuted and - fransit	Examiner	(Disease or injury that events resulting in dea	t initiated	Due to (or as a	a consequen	ice of):											
O, e be ex ysician burial	Aedical	¥UNPENDED		X AMENDED	item#2 tem#23a outcome of	1perFH, line f	23a,2 per/	7, perl E g860	E, g8	57.7/1 6/06	2/06 T	TT	12	3d. Date of	delivery		
Box 6876 The death certificate the attending physical for use as the	Physician/M	23b. Was decedent pre past 12 months?	egnant in the	1 Live	birth nant at time (2		al death er <i>(Specif</i>		Ectopic	pregnanc	;y		Month	,	ay	Year
s, P.O. E	Ď	Part II. Other significa	ant condition	ons contributing t	o death but i	not resulting	in the ur	nderlying c	ause giv	ven in Part	t I.			o use contri			of death? Unknown
Records The law requirence has been page 2 shoule	Completed										_	pe 1 ✔ Ye	as an topsy rformed? s 2	? r		ompletion	ngs available of cause of 2 No
tal ician: certiff	Be	25. Was case referred examiner?	to medical	Hospital:					10	of Death (0 Other;			7		7		
of Vital ing Physician After this cert funeral directo	n: To	1 Yes 2 27. Manner of Death 1 X Natural		28a. Date (Mont	Inpatient 2 e of Injury h, Day,Year)		ime of In	jury 28	c. Injury	at Work?	28	Home 5		dence 6 _	Other	-	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertification:	2 Accident 3 Suicide 6	Could	tigation 28e. Place	ce of Injury -	At home, fa	rm, street			es 2 1		8f. Location or Town		and Number	er or Rui	ral Route I	Number, City
Dito the Hospital within 24 hours a To the Funeral I completely filled	ပ	(Onder only		ysician: To the be	st of my know	-											
To th within To th	Medical	29b. Signature and titl	1 .	niner:On the basis and manner:	stated.	ion and/or ir	vestigati			number	urred at t	ne time, da		Date sign			
10		30. Name and address of person who completed cause of death (Item 23a) O.C.M.E. May 6, 2006															
		Susan Hogan		Assistant Medi	a		1 Penr	Street,	Baltir	nore, M	D 2120	01					· -
St Regist		31. Date filed (Month,	AY (9	2006	egistrar's Sig	griature	A. T. S. S. S. S. S. S. S. S. S. S. S. S. S.										

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene State
RegistramEND#18perFH5/1/06, BMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:58 MARINA 2006 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Mar. 3, 19 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs. Director 592-73-8214 89 1917 Peru Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. tnside City Limits 27 is marked other than "naturel", or Items 23a or 28a-f ehow traumstic event, the Macked Examiner must be mutified at 1 ☐ Yes 2√ No Directo Md. Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5022 Adrian Street 20853 Peru death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1X Yes 2□No Specify:Peru ģ Specify: Peruvian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Maria Rosa Piedra Maria Rosa Piedra 17. Father's Name (First, Middle, Last) Aurelio Yataco Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Marina Uribe (Daughter) 5022 Adrian Street Rockville, Md 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State April 28, 2006 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Va. 21. Signature of Funerat Service Licensee 22. Name and Address of Facility DeVol Funeral Home MELLA 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of) Examiner Overwhelming Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 Yes 21 No 2 No Attending Physician: After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 ₹ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 v topatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Vitin 24 hours after death.
To the Funeral Director: Alt 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061681 April 28, 2006 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert David Kirkraloy M.D. 9901 Medical Center Dr. Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 01 2006 Registrar

Thomas Arnold Vandervalk

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

omas Arnold		1- For State Certific	nent of cate of		d Mental H		Reg. N o.	200	6 152
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Thomas Arnold Vandervalk				2. Date of De Month April 28,		Year	3. Time of Death 1623 hrs
		4a. Facility Name (if not institution, give street and number) Deer Park Rd @ Baltimore City Reservoi	4	b. City, Town, or Finksburg	Location of Death		40	c. County of Deat Carroll	h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)	If Under 1 Year Months Day			irth(MM	Forei	rthplace (State or gn ountry) MD
ty		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow				1 000	0.5	1300	10d Inside City Limits
d how any e.		MD Carroll		''' minster					1 Yes 2 No
vlaryland 28a-f show d at once.	Director	10e. Street and Number	west	10f. Zip Code			10g Citi	izen of What Cou	untry?
ith the Maryland 23a or 28a-f sho notified at once.		302 Anita Drive		21	157			USA	
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f shu al Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No			spanic Origin? (S n, Mexican, Puerto		0-	14. Race - Ame White, etc.	rican Indian, Black,
s after ral", o	by F	Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No					ite
2 hours af "natural I Examin		15. Decedent's Education (Specify only highest grade completed) 16a Elementary/Secondary (0-12) College (1-4 or 5+)			tion (Give kind of e. DO NOT use ret		16b. i	Kind of Business	/Industry
5-0036 led within 72 Hygiene. other than the Medical	Completed		Super	visor/C	arpenter		W	ilder Ho	mes
		17. Father's Name (First, Middle, Last)			18. Mother's Name				
2121 uld be fil Mental F marked c event,	o Be	Arnie Vandervalk 19a Informant's Name/Relationship (Type, Print)	9h Mailing	Address (Strop	Wendy et and Number or	Vanderw			7:- Cada)
sho and 7 is	Ĕ	Jeanne Vandervalk/wife		Anita D		stminst			
ore, M s I and 2 of Health If item 2 her traum				ion (Name of ce		Date		Location - City or	
Baltimore, ormit. Pages I an Department of He Important: If ite njury or other tr		Bartar E Gordination o Removal from Glate		rematio	n Inc 5	/01/200	d F	lampstea	d, MD
Baltimo permit. Pages Department o Important: I		21. Signature of Funeral Servest icensee	22. Na Pr	ame and Address	s of Facility neral Ho				
A		23a. Part I. Eater the disease, or complications that caused the death. Do	not enter th	2 Washi	ngton Po	ad Wes	tmir	n gter, M	21157 Approximate Interv
Physician /Medical		failure. List only one cause on each line.	not onto a	o mode or dying,	, baom ao caraigo e	or respiratory ar	root, and	ook, or ribart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):							+
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause							
ed nsit	Exa	events resulting in death) Last Due to (or as a consequence of):							
50, te be executed ysician and burial - transit	ledical	UNPENDED AMENDED				·-··			
Box 68760, a death certificate be the attending physic ed for use as the burn	Med	IF FEMALE: 23c. If yes, outcome of pregnance	у	-			230	d. Date of deliver	у
Box 6876 he death certificate the attending phy hed for use as the left.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	- =	al death 3	Ectopic pregna	ancy		Month	Day Year
Box death the atte	nysi	1 Yes 2 No 9 Unknown 9 Unknown	□ Oth	er (Specify)			Ĺ		
P.O. E es that the d igned by the detached	by PI	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause (given in Part I.				the cause of death?
ords, P.C w requires that is been signed b should be deta	ted t								bably 4 Unknown
Division of Vital Records, tat or Attending Physician: The law requires a star dealh. In Director: After this certificate has been sided in by the funeral director, page 2 should be a by the funeral director, page 2 should be a by the funeral director.	Completed					24a. Was auto			utopsy findings available completion of cause of
Re(: The ificate r, page		25. Was case referred to medical		OC Disease	of Dooth (Chool)	1 Yes			es 2 No
1 of Vital Rec ling Physician: The After this certificate funeral director, page	o Be	examiner?	Outpatient		Other Nursit	na Home 5	Reside	ence 6 🗸 Othe	r: Scene
of \ ng Phy \ter th		27. Manner of Death 28a. Date of Injury (Month, Day Year)	. Time of In	jury 28c. Inju	iry at Work?	28d. Describe			
tendi death.	atio		OUND: 40 hrs	1	Yes 2 V No	Subject ha	igea s	seii	
Division pital or Attene ours after death teral Director: filled in by the	ertification:	3 Suicide 6 Could not be determined (Specify) Woods	farm, street	, factory, office b	ouilding, etc.	or Town,	State)		ural Route Number, Cit
Lospitz Lospitz Loues Loues Loues Loues	ပ	4 Homicide 29a. Certifier A Continue Division To the heat of an Insulation	leath occurr	ad at the time d	ato and place, and			Finksburg, N	
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 2 Medical Examiner: On the basis of examination and/o and manner stated.							
1	Me	29b Signature and title of certifier		29c. Licens	se number		29d.	Date signed (Mo	onth, Day, Year)
MIL		Theda U. Kelma		O.C.	M.E.		Apri	il 29, 2006	
5		30. Name and address of person who completed cause of death (Item 23a		n Ctroot D	Itimora MD 0	1201			
	tate	Theodore King MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 egistrar's Signature	111 Per	ın Street, Ba	ıltimore, MD 2	: 1201			
Regis		MAY 0 1 2006 Steven &	hour	Es.					
MH 17 Rev 1/2	2001	0	RIGINAL						

State of Maryland / Department of Health and Mental Hygiene ? 1 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 **Physician** 12:59 P M April 25, Barbara Jeannette Bunker Vercelli /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 10-8-1944 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Yrs. California Director 218-40-6973 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthen "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Edgewater Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21037 USA 1725 Fairhill Drive filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White \$ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 5+ years United Methodist Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event 90x8. Be Helen Masten Fred Ottinger 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candyce A. Hilgenberg/Daughter 1725 Fairhill Drive, Edgewater, MD 21037 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4-28-06 Asbury UMC Cemetery Arnold, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur / Mineral Pervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home UM 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pnysician Respiratory failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Metastatic Uterine Cancer S- uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete 1 ☐ Yes 2 🕅 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No andin,
r death.
tor: After th.
q funeral de this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 00 1321200U 30 Motor and address of person with completed cause of death (Item 23a) (Type, Print) Robert Kirkcaldy, M.D. 9901 Medical Ctr. Drive, Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [6] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 27, 2006 **Physician** 1:23Pm William Joseph Williams /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles La Plata Civista Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1945

Months Days Hours Min. (Month, Day, Year) 1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 7.777 **Funeral** 1₩ 2□F Yrs. 61 Director 233-70-6461 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at La Plata Charles MD 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20646 10322 Charles Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher High School . Pages 1 and 2 should be filed w itment of Health and Mental Hygie tant: if Item 27 is marked other t ilury or other traumatic event, ID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Margaret Williams William Carlos Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 57, La Plata, MD 20646 19a. Informant's Name/Relationship (Type, Print) Anna Williams/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ortant: F Sacred Heart Cem. 5/2/06 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 permit.
Depertrimports
Imports
eny inju 21. Signature of Funeral Service Licensee AREHARTSECHULS FUNERAL HOME, P.A. · C 211 ST. MARY'S AVE. LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of) Examiner Streptococcus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner Respiratory Failure physicien and the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ettending ph for use es (IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) certificete has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Acute and Chronic Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Mellitus, Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2√ No After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in The Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-23021 May 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sanjeeb K. Mishra, M.D. 7C Post Office Rd. Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Asgistrar's Signature State

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Registrar

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			For State Registrar	State of Maryland / t	Certificate of Death	ental myglei Reg.		10001
	Physici /Medio			nell Watts.	Jr.	2. Date of Death Month	Day Year 7	3. Time of Death 5456AM
	Examir		4a. Facility Name (If not institution, give UNIVEYSITY SPECIA	Ity Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director			7. Age (In yrs. last bir	Yrs. If Under 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye FED 10, E	9. Birth Cou	nplace (State or Foreign untry)
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State M.D. Freder	tick 10c. City, Tow Walke				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a	ai Director	10e. Street and Number 8330 Revel a	tion Ave	10f. Zip Code 21793	10g.	Citizen of What Col	untry?
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: BL	, etc.
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land 2	ld be filed ental Hygi kad other ic evant, i	To Be C	17. Father's Name (First, Middle, Last) DWayne D. Wa			(First, Middle, Maio	*	
Maryland	nd 2 shou aith and M 27 is mar ir traumat	 -	19a. Inform t's Name/Relationship (T) Chairmaine	iype, Print) 19b	. Mailing Address (Street and Number or Rura. 330 Revelation 1	Route Number, Cit	y or Town, State, Zi	(p Code) Md 2179
Baltimore,	Pages 1 an nent of Heal ant: If itam 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State 20b. Place o cemete FanVI	f Disposition (Name of ry, crematory or other place) We Cem. May 6,	2006 F	Location - City or T	own, State
Balt	permit. Pa Departmer Important any injury		21. Signature of Funeral Service License	lleis .	ew Cem. May 6, 22. Name and Address of Facility 5 West South St	aneval hedench	t med 2	4701
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68760,	rtificate be executed ng physician and as the burial-transit	cai Examiner	cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence d.				
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	juires that n signed by	by	Part 11. Other significant conditions co Chronic nead for Multiple decubit	ontributing to death but not resulting in	n the underlying cause given in Part I. \$ 1 + (4 perfension)	23e. Did tobacc	o use contribute to	the cause of death?
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Vital	sician: certific rector,	o Be C	25. Was case referred to medical	9	26. Place of Death stpatient 3 DOA Other: 4 Nursing Hom	(Check only one)		
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	To tha Hospital or within 24 hours afte To the Funaral Dir completely filled in	edical	29a. Certifier 1 Certifying Phy cone) 1 Medical Example	rsician: To the best of my knowledge iner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place, a d/or investigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due t	stated, to the cause(s)
	Tot with Tot	M	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
	2		30. Name and address of person who c	H Gol south of	larter st Balhmare	MD 2/2	30	
	Sta Registr		31. Date filed (Month Pay, Year) 2 .2	32. Sgistrar's Signature	Sparie			

WATTS DWAYNE

			1 - For Amend # 10c	State of Marylan per/fh 05-02-	d / Depa - 2006 e	rtment of F	lealth and M Death		giene leg. No. 006	15302
			Decedent's Name (First, Middle, Last					2. Date of Dea	th	3. Time of Death
	Physici /Medio		SHERRY DANK	lette Wim	5			ADRIC	29 206	3:30 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	1
			9705 SpENCES				Brill		FREDERI	
	Funeral Director		210 10 100	x 7. Age (In yrs.	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Birth (, Year) 9. Birth 21, 1962 Filed	aplace (State or Foreign untry) XRULL PM:
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits
	Marylan f show	ŏ	md. FRADERIC	ve FRE	DENCH	_ Ijam	sville			1 PYes 2 □ No
	28e-	rect	10e. Street and Number			10f. Zip Code			l 0g. Citizen of What Co	untry?
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	death	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. W	/as Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Amei	
9	or Ite	/Fu	1 Never Married 2 Married	1 Tes 2 No		☐ Yes 2 No	Specify:	rican, etc.)	Specify: BL	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-1 show the Medical Eventirer rusal by Instillind at		3 Widowed 4 Divorced	Year or Dates:						
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	filled Hygi other	Be C	17. Father's Name (First, Middle, Last)	-			18. Mother's Name			
<u>a</u>	lid be fental rked ric ev	To B	Earl A. Wim	5 Jr.			Arlene	- Hu	bbard	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. tiem 27 is marked other than "naturel", or Items 23e or 28e-1 show other treumetic event, the Medical Examiner mast be multiped at		19a. Informant's Name/Relationship (T	ype, Print)					r, City or Town, State, Z	
	and 2 ealth n 27 I		Arlene Wims				er Lane	15m	nsville M	1. 21754
ore	or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	1 6	lace of Dispos emetery, cremi	atory or other plai	ne)		20c. Location - City or 1	
Ĕ	Pages ment of ent: If it		Donation 5 Other (Specify,	Eb					006 IJM	wike md
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr. Once.		21. Signature of Funeral Service Licens Fully Z. Fol	lus	64 110	Name and Addre	SOUTH S	eval Ho	othice mo	21701
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death ne cause on each line.	n. Do not ente	r the mode of dyir	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between
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8760,	cate be executed physician and i the burial-transit	dical		d						
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Box	h cert endin	N/UE	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal	ncy Ideath 3⊡l	Ectopic pregnancy	1		23d. Date of deli	
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ion	Attending For death. ector: After by the funera	atio	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
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	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medicai		rsician: To the best of my kno iner: On the basis of examina and manner stated.						
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	1/			ompleted cause of death (Item	23a) (Type, P	Print) -th	Stratt	Freder	ick, MD.	21701
	V		31. Date filed (Month, Day, Year)	ander, MD	50 I	مه	Jiel !	, , , ,	, ,	
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State of Maryland / Department of Health and Mental Hygiene 15303 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Gwen Ellen 29, April 2006 1:05 A /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Yrs. 087-20-6204 Director Nov. 25, 1928 Michigan Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rei', or iteme 23a or 28a-f ehow Examiner must be notified at 1 Yes 2 □ No Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Russell Avenue -Apt. 211 20877 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ۵ Specify: White 3 XWidowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Library Librarian event. If 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Pages 1 and 2 should be ပ Hurlbert Bridgewater Luthie Ligon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important; if item 27 is eny injury or other treu 10503 Brenda Avenue, Ijamsville, Maryland Daniel Ligon Ward - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Forest Oak Cemetery 5/06/06 Gaithersburg, Maryland 21. Signature of Funeral Septe Licenses 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland Korut 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760 Completed by Physician/Medical 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Small bowel obstruction 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No certificate has t autopsy perform rmed? 2X No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA his : After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel I

completely filled To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0061681 April 29, 2006 ss of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Robert D. Kirkcaldy, M.D. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 2 2006 Registrar

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene
1-For State

Amend

State of Maryland / Department of Health and Mental Hygiene
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State of Maryland / Department of Health and Mental Hygiene Bernard Franklin Wathen Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 26, 2006 1315 hrs Franklin Wathen Bernard Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Welcome 5665 Marshside Pl 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Min. Director Count Maryland 1 XM 2 Yrs November 216-50-7239 62 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location Yes 2 X No Welcome MD Charles 28a-f show notified at once Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 5665 Marshside Place 20693 USA 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14 Race - American Indian, Black must be White etc Armed Forces? 1 Never Married 2 X Married Yes 2X No White 1 Yes 2X No specify: If Yes, Give Year Specify Widowed Divorced the Medical Examiner "natural", ş 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Flementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Operator/Foreman 11 Heavy Equipment 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Baily Bernard F. Wathen, Sr. marked æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) .2 P.O. Box 171 Nanjemov, MD 20662 Vickie Carey/Daughter 27 t: If item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition 05/04/2006 crematory or other place) Burial 2 Cremation 3 Removal from State Oueen of Peace Helen, Maryland 5/4/04 mportant: nent Donation 5 Other Specify: ature of Funeral Service Licenses ÄREHART-ECHULS FUNERAL HOME, P.A. M00945 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear PT.ATA MD Physician failure. List only one cause on each line Between Onset and /Medical Death a. Ciirhosis of the Liver due to Alcohol Abusei Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown s been signed by the should be detached t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy After this certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: funeral director, 25 Was case referred to medical Division of Vital Be Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene DOA Inpatient 2 FR/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural 1 Yes 2 No d in by the f 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide 24 hours a Funeral ! (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started completely **Medical** within 2. Medical Fxaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. 29c License number O.C.M.E. April 27, 2006 30. Name and address of person who complet ed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. 31. Date filed (Month), Apr. gistrar's Signature State 2006 Registrar

			For State Registrar	State of Maryland			nt of H		nd Me		iene	006	15	305
	*		1. Decedent's Name (First, Middle, Last)						2	. Date of Deat Month	th Day	Year	3. Time o	
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	Examin	54 2	4a. Facility Name (If not institution, give : CLINTON NURSING	HOME		CLI	NTON	Location of			PR		EORGE'S	
	Funeral Director		229-50-4227	7. Age (In yrs. Ia.	st birthday) Yrs.	Months Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, ULY 9	Year)		rthplace (State country) RGINIA	or Foreign
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside C	City Limits
	death with the Maryland ime 23s or 28s-f show r.must be notified at	to	MD PRINCE G	EORGE'S LAI	RCO								1 X Yes	s 2 No
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lan	2 should to and Ment is marked sumatics		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Addres	s (Street a	nd Numbe	r or Rural I	Route Number	City or	Town, State,	Zip Code)	
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Ë	Pag Iment tant: jury c		4 ☐ Donation 5 ☐ Other (Specify)	ST .	JAMES								LE, VIRG	
Bal	permit. Pages 1 Department of H Important: If its any injury or of once.		21. Signature of Fundral Service Licens 23a. Part1. Enter the disease, or compl	\geq	74	474 L	ANDO		OAD L	ANDOVE	R, M/		AL HOME D 2078	35
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		inol.	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	м	28c. Injury Work			d. Describe ho	ow injury	occurred		
Division	or Attanation description of the Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, st			′es 2 □ N		f. Location (Si City or Town		Number or R	Rural Route Nur	nber,
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0	(1)		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print)		*						
	0		MICHAEL SIDARO			GSTON	ROA	D # 1	01 FT	. WASH	INGT	ON, MAR	YLAND 2	20744
	Sta Registi		31. Date filed (Month, Day, Year) ADD 2.8 2006	2. Registrar's Signatu	las	R.								

Amended Part II, nls, 04/21/06, Allegany Co.

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / D

epartment of Health and Mental	Hygiene	1	1
Certificate of Death	Bog No.	U	U

2. Date of Death

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3. Time of Death

APRIL 20, 2006

	Physicia /Medic			ne <i>(First, Middie, La</i> : Idward		Robert		V	lalto	on		Month APRIL	20		0525 M
	Examin			(If not institution, given HOSPITAL		')		•	Town, or IBERI	LAND	of Death			c. County of Dea LLEGANY	th
	Funeral Director		5. Social Security 212-44-5	_	6ex 7. A	ge (In yrs. last bin	rhday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 08/18/	ay, Year) Co	thplace (State or Foreign buntry) y land
	D .		Usual Residence	of Decedent		10c. City, Town	n or Loca	ation							10d. Inside City Limits
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:	death with the	era	11. Marital Status		12. Was Deceden	t Ever in U.S.		as Deced			gin? (Spe	cify Yes or No	0-	14. Race - Am	
	72 hours after of naturel', or ther alcal Examinat	by	1 🗌 Never Ma	rried 2☐ Married 4 🖔 Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	ĮΝο	1	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:				Black, White, etc. Specify: White			
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Maryland	es 1 end 2 should be filed of Heelth and Mental Hygii f Item 27 is marked other r other treumatic event, in			Name/Relationship (145								or Town, State,	Zip Code) ternport, MD
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Baltimore,	if lte		1 D Burial	2 Cremation 3	Removal from Stat	0	•	atory or c			1/. / 21	/2006		•	
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Ba	Deperment of the population of			140	del	1								nd, MD	21502
			23a. Part1. Ente	r the disease, or come art failure. List only	plications that caus	the death. Do	not enter	r the mod	le of dyir	ng, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between
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68	tificate ig physi as the l	ed											U,		
		Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1 Yes 19 Unknow	12 months? 2 □ No		ne of pregnancy 2 Fetal death at time of death		Ectopic p Other (sp			_			23d. Date of de Month	livery Day Year
Records, P.	Se Co	۵	Part II. Other sig	nificant conditions	contributing to death	but not resulting i	n the un	derlying o	ause giv	ren in Part I	l.		tobacco		o the cause of death?
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Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicid	6 □ Could not t determined	4 200. Flace UI	Injury - At home, fa etc. <i>(Specify)</i>	arm, stre	et, factor	y, office			28f. Location City or To			lural Route Number,
	e Hospit 24 hours e Funera etely fille	Medical C	29a. Certifier (Check only one)		hysician: To the be miner: On the basis and manner	of examination ar									
	To th within To th compl	Me	29b. Signature a	nd title of certifier				29	c. Licens	se number			29d. D	ate signed (Mon	ith, Day, Year)

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State Registrar

VIK POONAI, M.D. 924 SETON DRIVE CUMBERLAND, MD 21502 istrar's Signature 31. Date filed (Month, Day, Year) APR 2 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D36766

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 00:04 2006 April Walter H. Wilkerson, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Healtheare Agnes None If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. Months Days Hours Min. March 3,1944 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 15€M 2□F Maryland Yrs. Director 216 42 6232 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itema 23a or 28a-f ahow the Modical Exeminer must be notified at 1 ☐ Yes 2 XNo Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 United States 8521 Old Frederick Rd by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 XNo f Yes, Give 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Right of Way Agent State Highway Admin. other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any fully or other traumatic event 90c8. 17. Father's Name (First, Middle, Last) Be Lillian Kefauver Walter H. Wilkerson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8521 Old Frederick Rd Ellicott City, MD 21043 Loretta J. Wilkerson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd Cem. 5-3-2006 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final encephalopathy Anoxic Pnysician 24 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): 24 hours Examiner de to (or as a consequence of): Sequentially list conditions, if any, is a line to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🕅 No throm & 3 Probably 4 Unknown dizease ventricle Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an ure disorder certificate has autopsy performe 1 ☐ Yes 2 ☐ No Status cardio Du monary arrest post 25. Was case referred to medical examiner? Be 26. Place of Death Check only he examiner? Other: 4 Nursing Home Hospital: 2 ER/Outpatient 3 DOA the funeral dire 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manper of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated

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Wilkerson

Hospital or Attending

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) MAY 0 1 2006

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29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coarte)

29c. License number

19511

Baltimore

29d. Date signed (Month, Day, Year)

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April

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 06, May 4:00A M 2006 Esther Wood 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford 471 Paradise Road Aberdeen | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 0 4 / 3 0 / 1 9 1 8 9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 X F 88 Yrs 137-56-0226 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ¥ Yes 2 □ No Harford MD Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 U.S.A. 724 Green Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②ONo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 'n Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Esther Dillon Walter Sayres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 Green St., Mary Leonetti (daughter) Havre de Grace MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington Cem. 5/10/2006 Pennsauken, NJ 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, 333 S. Parke St., Aberdeen, P.A. MD 21001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after deafur. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as ones.

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Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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Sequentially list conditions, if any, leading to immediate eaust. Enter Underlying Cause (Disease or injury	b									
Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		te of delivery nth Day Year						
Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes 2 🗷 No	nibute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available						
			autopsy performed?	prior to completion of cause of death?						
25. Was case referred medical		26. Place of De	ath (Check only one)							
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence 6 ☐ Oth	er (Specify) grandson						
27. Manner Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how injury occurr	ed						
3 Suicide 6 Could not be determined		treet, factory, office	28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,						
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysicien: To the best of my knowledge, deaminer: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the cause(s) and ma arred at the time, date and place,	and due to the cause(s)						
29b. Signature and title of certifier	01/2 . 2 -	29c. License number	29d. Date signer	(Month, Day, Year)						

e GRACE Md.

State

Registrar

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

8 2005

S. Union

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31. Date filed (Month, Day, Year)

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32. Registar's Signature

Moure

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. Month Ar 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year **Physician** 1245 arence ori 2006 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 15el Hir Harford orien If Undar 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Yrs. 58 New Jersey Aug 21, Director 143-40-6198 1947 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after deeth with the Marylend 10c. City, Town or Location 10a State 10b. County 1X Yes 2 □ No Aberdeen Director Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number r Herns 23a or ulrer must be r 21001 16 E. Aztec Street Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0020 7 is marked other than "natural", or traumatic event, the Medical Exam 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Mechanic Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Peges 1 and 2 should be fill ment of Health and Mental H ant: if item 27 is marked out Florence Matthews Clarence L. Worthy, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 16 E. Aztec Street, Aberdeen, Maryland 21001 Barbara Worthy / wife 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of I important: if its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Tomsriver, NJ Ocean County Memorial Park 5/3/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CEREBROVASCULAR ACCIDENT F miner Due to (or as a consequence of): Physician/Medical Examiner physician end s the buriel-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown DIABETES þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 2X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Yes 1 🗆 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2)21 No 2 ER/Outpatient 3 DOA After this funeral 28e. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Natural 2 🗆 No 1 Yes death. 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter der To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier 145344 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 6225. UNION ANE HAVRE DE GRACE MD SURESH DHANJANI 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Maryland / Depa	artment of Health and		•						
Cer	tificate of Death	Reg.							
			Day Year 3. Time of Death						
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ber)	4b. City, Town, or Location of D		4c. County of Death						
e Center 7. Age (In yrs. last birthday)	Mitchel If Under 1 Year If Under 24 I		Prince George's						
95 Yrs.		Min. (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country) 1911 Arkansas						
10c. City, Town or Lo	cation		10d. Inside City Limit						
	Washing	rton	1 <u>X</u> Yes 2 □ N						
	10f. Zip Code		Citizen of What Country?						
	20011		United States						
	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pi	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.						
2 📉 No	1 ☐ Yes 2 🏋 No Specify:	onto rindiri, dio.)	Specify: Black						
16a. Deced	dent's Usual Occupation kind of work done during most of	warking 16b	. Kind of Business/Industry						
4or 5+)	DO NOT use retired)								
Edu	cational Psycho		Government						
	18. Mother's	Name (First, Middle, Maid	den Sumame)						
		Minnie B	ranch						
	ng Address (Street and Number of								
	33 Round Table I								
20b. Place of Dispo- cemetery, crem	sition (Name of natory or other place)	Date 20c	. Location - City or Town, State						
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 4/29/2006 C1i 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral 1									
115 22	. Name and Address of Facility	Stewart Fu	neral Home						
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f Injury 28b. Time of Injury Injury	Work?	28d. Describe how in	njury occurred						
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of Injury - At home, farm, stre g, etc. <i>(Specify)</i>	eet, factory, office	City or Town, St	t and Number or Rural Route Number, ate)						
best of my knowledge, death sis of examination and/or inv er stated.	occurred at the time, date and placestigation, in my opinion, death o	ace, and due to the cause ccurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)						
1	29c. License number	29d.	Date signed (Month, Day, Year)						
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of death (Item 23a) (Type.			11p1 11 21, 2000						
		Suita 502	Lanham, MD 20706						
[of death (Hem 23a) (Type, Print) .D. 7404 Executive Place,	of death (Item 23a) (Type, Print) .D. 7404 Executive Place, Suite 502,						

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16.05	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of De	eath Day	Y	'ear	3. Time of Death
	/Medic		James Yat								April	22	200)6	11:30A M
	Examir	er	4a. Facility Name (If not institution, giv		.1. 0		4b. City,		Location of			4c.	County of		
	Funeral		Collingswood Nurs 5. Social Security Number 6. S			last birthday)	If Under	1 Year	ckvil If Under 2	4 Hrs.	8. Date of Bi (Month, Da	rth	Mor	tgon	nery nce (State or Foreign ry)
	Director		578-36-3982	X M 2□ F	77	Yrs.	Months	Days	Hours	Min.	Feb. 6	а <i>у</i> , Үөа <i>г)</i> 5. 19	29), DC
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	calion								
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	r deal	Iner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13. V	Vas Dece	dent of His			cify Yes or No Rican, etc.)		14. Race -		n Indian,
36	s afte	by FL	1 Never Married 2 Married	1 X Yes 2 □ N If Yes, Give Year or Dates:	No		Yes		Specify:		,,		Specify:	B1a	
9	filed within 72 hours after death with the Maryland Hygiene. Wher then "naturel", or items 23a or 28a-1 ahow with the Medical Examican must be incitiled at	ed b	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Ed			16a. Deced	lent's Usua	al Occupa	tion			16b Ki	nd of Busir		
215	hin 72 B. In "nu	Completed	(Specify only highest gra	de completed) College (1-4or 5	·+)	(Give		rk done d	uring most	of workii	ng	700.10	10 01 00311	1033/11/00	istry
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Maryland 21215-0036	th an		Grant P. Yate	** '					Place				DC 20		iode)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f ahow may injury or other traumatic avant, the Medical Examt as must be notified at ance.		20a. Method of Disposition		20b. P	lace of Disposemetery, crem	sition (Nar	ne of			ate		cation - Cit		n, State
E	Pages nent of H ant: If Ita		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			antico				4/2	8/06	ťΓı	iang	1e. '	VΑ
alt	epartr epartr portu y inju		21. Signature of Funeral Service Licer	1560	-				s of Facility		ewart				V 21
Jan .	g ∪ ਦ ≅ 9		23a. Part1. Anter the disease, or com	Hewary,	44						Rd., NE		sh.,	DC 2	0019
8760,	Physician and /Medical Examiner physician and physician and physician its physician it	cai Examiner	shock of heart failure. List only Immediate (Calyse (Final disease or sopdition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last		ple N a consequ Dise a consequ	ease uence of):	1								nterval Batween Onset and Death
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the companies of	2 🗌 Fetal	death 3	Ectopic pr Other (sp					2	3d. Date o Month		, ay Year
S, F	es tha gned be det	by P	Part II. Other significant conditions of	ontributing to death bu	ıt not resu	ulting in the un	derlying c	ause givei	n in Part I.			**			cause of death?
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DIVIS		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At ho . (Specify	me, farm, stre	et, factory	, office		2	8f. Location (3 City or Tox	Street and wn, State)	Number o	or Rural F	Route Number,
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	De		30. Name and address of person who a Anushira	completed cause of de avan Dadgar				nield	s Dri	Ve.	Bethes	da	MD 2	0817	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 2 7 2006	32. Registra						,	2001100				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 23b per doc 8855 5-16-06 vt.
State of Maryland / Department of Health and Mental Hygiene / 1 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month :55 AM **Physician** 0 rsor /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner es HOM Age (In yrs If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day last birthday) **Funeral** Months Days Hours Min. 2/9-18-97/ Usual Residence of Decedent 1 M 2 F Director 10c. City, Town or Location 10d. Inside City Limits, 10a, State 10b. County or 28e-f show th and Mental Hygiene. ?7 is marked other then "natural", or flems 23s or 28e-f show traumatic event, the Medical Examinar mast be notified at 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA permit. Peges 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23 any injury or other traumatic event, the Modical Examples many injury or other traumatic event, the Modical Examples in Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Neyer Married 2 ☐ Married 21215-0036 1 Yes 2 No Specify: Whit Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

A 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Countina Dartmen Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathe Name (First, Middle, Last) Be mabee odosia 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21014 Belarmo 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State faneral 10 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral SNew Sinwest Port ForestHill 21050 Dr 23a. Part1. Enter the disease or complicate shock, or heart failure. List only one tions hat caused the death. Do not enter the mode of sing, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician alling 1 -6 /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispuss or injury) Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): as the the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year ō 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Cther: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o Director: After that in by the funeral 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: Division 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after filled the Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) To 2255 200 12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) macPha. Belon n 615 W 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 6 2006 Registrar

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I Eme | Anderson

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 15, 2006 Year Physician 10:00 A HAZEL M. AHLSTROM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ESSEX Baltimore Riverview Care Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign County) | April 11,1922 | North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 84 220-34-5608 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow the Medical Examiner must be notified at MD Baltimore Rosedale 1 Yes 2 No Funeral Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5432 Litany Avenue 21237 238 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 5 1 ☐ Yes 2 X No Specify: <u></u> 3 □XVidowed 4 □ Divorced naturei Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Chapman Cleve, Sr. Georgia Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) importent: if item 27 ier any injury or other traum Richard Ahlstrom-Son 5432 Litany Avenue-Rosedale, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gardens Of Faith 1 XBurial 2 Cremation 3 Removal from State 5-18-06 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road-Parkville, MD 27234 1= fadde 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SINU /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-translt Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THROMBOSIS VENOUS 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No should l 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an performed cartificate 200 No 1 🗌 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this cartific comple by filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State 6 2008 Registrar

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760,

Division of Vital

			1 - For State Registrer	State	of Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of Hotel	ealth a D <i>eath</i>	and M	ental Hy	giene Reg. No		06	15314
	Physicia	an	1. Decedent's Name (First, Middle, L Stella	ası) Arscot	+						2. Date of Do Month	ath Da	ıy	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, g				4b. Cit	, Town, or	Location of	of Death	May	12	. County	of Death	23:03pM
	Examini	eı	Union Memoria					Balti	Lmore				N/A	A	
	Funeral		5. Social Security Number 6. 219–22–6054	Sex 1 □ M 2√C3√F	7. Age (In yrs. 81	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year, 21,1	0.25	Cour	place (State or Foreign
	Director		Usual Residence of Decedent		01			11			Jan. 2	21,1	923	temis	sv1vania
	arylan ehow	_	10a, State 10b. County			ty, Town or Lo		1						1	10d. Inside City Limits 1 ☐ Yes 2√√No
	the M	ecto	Maryland Balt:	imore Co).	Luthe		LE lip Code			1	10a, Ci	itizen of V	What Cour	
	h with	io ie	8700 Vallevfield	d Road					093			US.			,
	r deet	Funeral Directo	11. Marital Status	Armed F	cedent Ever in U orces?	J.S. 13.	Was Dec	edent of His	spanic Ori	gin? (Spe n, Puerto I	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,	can Indian, etc.
000	be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. do ther than 'naturel', or iteme 23s or 28s-f ehow event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 3 √Widowed 4 Divorced	l 1 □Yes If Yes, G Year or	ive X Dates:		1 ☐ Yes	X ▼ No	Specify:				Specify	· Whi	ite
5	72 hou		15. Decedent's (Specify only highest of)	16a. Dece	dent's Us	ual Occupa	tion	t of workii	na	16b. k	Kind of Bu	usiness/în	dustry
7	within	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life.	nemal	use retired)	,				O	wn Ho	ν π Θ
7	filed Hygie other ent,	0	12 17. Father's Name (First, Middle, Lat	st)		1101	пешаг		18. Mothe	er's Name	(First, Middle	, Maider			JIIC
/іапа	uld be Menta wrked stic ev	To B	Frank Simmons							Mar	<u> </u>				
200	12 shc h and 7 le mu treum		19a. Informant's Name/Relationship John Arscott	(Type, Print) Son							I Route Numb				1and 21093
5	tem 2 tem 2 other		20a. Method of Disposition		20b. I	Place of Dispo	sition (N	ame of	1		ate				own, State
Ē	Pages nent of nt: If I		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donatien 5 ☐ Other (Spec		1 State _	cemetery, crer $1 exttt{timore}$	-			5/16	/2006	Ba1	timo	re. M	1D
Бащтог	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Interportent: If term 27 is marked other than "naturel; or Iteme 23a or 28a-1 show any Injury or other treumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Lig	ensee /	2			and Address			Funera	l Hai	mo .	Inc	21211
u:	<u> </u>		23a Part Error the disease or co	molications that	ns.	36	531.1	alls	Road	. Ва	ltimore	<u> </u>	D .	inc.	Approximate
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	certifi nding I use es	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn								23d. Dat	e of delive	ЭГУ
Ö	w requires that the death certifi been signed by the attending should be detached for use es	Physician/Me	in the past 12 months? 1 Yes 2 No		birth 2 Feta gnant at time of c		JEctopic Other (pregnancy specify)					Mo		Day Year
Э	hat the od by ti detach	Phy	9 ☐Unknown Part II. Dther significant conditions			sulting in the u	nderlying	Cause dive	n in Part I		23a Did	tobacco	use conti	ribute to th	he cause of death?
necoras,	The law requires that ate hes been signed b age 2 should be deta	d by		outing to		outing in the di		cause give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•			□No	3 ☐ Prob	
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ō	Physer this eral di	n: To	1 ☐ Yes 2 ♠ No 27. Manner of Death	28a. Date	of Injury	28b. Time of		28c. Injury Work	4 140		ne 5 Res 28d. Describe				ý)
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	To the Hospital or Attending Physicien: within 24 hours alter death To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To th	e best of my kno	owiedge, deati	h occurra	d at the time	e, date an	nd place, a	and due to the	cause(s	and ma	inner as s	tated.
	the Ho in 24 the Fu ipletely	ledical	(Check only 2 Medical Ex	aminer: On the	basis of examina nner stated.	ation and/or in	vestigatio	n, in my op	inion, dea	th occurre	ed at the time,	date an	d place, a	and due to	the cause(s)
	Veit Con	Σ	29b. Signature and title of certifier	1 vgr			2	9c. License AT		942			_		Day, Year)
	2		30. Name and address of person wh	o completed car	∴ (Ite	m 23a) (Type	Print)					14	ay "	2,20	
	3		WALID BARB	our, M	.D. Un	ion Me	emor	ial He	spite	al, I	410				
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 20	1 27	Registrar's Sign	ature /oc	NE S								

			1 - For State Registrar	State of M			of Health and of Death	Mental Hy	/giene Reg. No. 2	15315
	Physici	20	1. Decedent's Name (First, Middle, La					2. Date of De Month	nath 12 2006	3. Time of Death 1:20 A M
	/Medic		Shirley Jean Agn					May		
1	Examin	er	4a. Facility Name (If not institution, giv				wn, or Location of Dea	ath	4c. County of Dea	
			Stella Maris Hos 5. Social Security Number 6. S		e (In yrs. last birthda)	Timon		s. 8. Date of Bi	Baltimor	
и	Funeral Director		1	□M 2 X F	59 Yrs.		Days Hours Min	. (Month, D.	ay, Year) . c 1, 1947 Bal	rthplace (State or Foreign ountry)
	ס		220-52-4697 Usual Residence of Decedent					AUI. Z	1/ 1/4/ 1001	
	arylan show		10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f.	oc to	Maryland Cecil		Port Dep				40-07	
	Mith th	Dir	10e. Street and Number 1305 Belvidere Ro	ad		10f. Zip C 2190			10g. Citizen of What C	ountry?
	72 hours after death with the Maryland natural; or items 23s or 28s-f show deal Executes out be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13			Specify Yes or N		erican Indian,
10	fer d	F	1 Never Married 2 Married	Armed Forces? 1 Yes 247 If Yes, Give	No		nt of Hispanic Origin? (Cuban, Mexican, Pue V	irto Rican, etc.)		ite, etc.
93	ral', o	P	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Tes 2	No Specify:		Specify:	White
21215-0036	72 hc	Completed	15. Decedent's E (Specify only highest gra		(Giv	edent's Usual of work	done during most of w	orking	16b. Kind of Business	s/Industry
21	Athin Pa.	μ	Elementary/Secondary (0-12)	College (1-4or	5+) life.	<i>DO NOT use</i> ata Ent	retired)		Check Prir	nting Co.
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Maryland	d be fundal h	Be c	Leonard Joseph A		î•			rie Ann		
Z	Should Me mark	ဥ	19a. Informant's Name/Relationship (ling Address (S	Street and Number or I	Rural Route Numb	ber, City or Town, State,	Zip Code)
	alth as 27 is rrtrau		Marge L. Gleason/	sister	1305	Belvid	ere Rd., P	ort Depo	sit, Maryla	and 21904
Je,	itsm itsm other		20a. Method of Disposition		20b. Place of Disposemetery, cr	oosition (Name ematory or oth	of er place)	Date	20c. Location - City o	
Ē	Page nent c ant: If ary or		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special	JHemoval from State (x)	Hilltop	Servic	e Corp. 5-	16-06	Towson, N	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exeminer count for notified at ODGS.		21. Signature of Funeral Service Lice	hsee					Funeral Hongdon, MD 210	•
	Physician		23a. Hart1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine.		of dying, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
4	/Medical		disease or condition resulting in death)		TRIAL CANC a consequence of):	EK				
	Examiner		Sequentially list conditions,	b	and State of the Control of the					
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687	ficate g physics as the			_ d.						
Box	eath certific attending pl for use as t	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic preg	102004		23d. Date of de	alivery
	se deat the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	4☐Pregnant a		Other (spec			Month	Day Year
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Re	m (2) C1	Ę.						auto	formed? death?	tutopsy findings available completion of cause of
<u>a</u>	in: Ti ificate or, pa		25. Was case referred to medical	100000	-6100		26 Place of D	1 ☐ Yes eath (Check only		s 2 No
<u>=</u>	Physician: The Is this certificate har ral director, page 2	To Be	examiner? 1 ☐ Yes 2 📆 No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpati	ent 3□ DOA	1 04		sidence 6 KOther (Sp.	ecity) HOSPICE
o	g Phy er thi	n: T	27. Manner of Death	28a. Date of Inju			c. Injury at Work?		how injury occurred	oon)) HOUTTOE
Ö	uttending death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation	n	19 7047) 1111413	М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	r Atterder de l'recto	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	286. Place of in	jury - At home, farm, : tc. (Specify)	street, factory,	office	28f. Location City or To	(Street and Number or Fown, State)	Rural Route Number,
	oital ours af									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai			of examination and/or				e cause(s) and manner a e, date and place, and du	
	o the	Z.	29b. Signature and title of certifier			29c.	License number		29d. Date signed (Mor	oth, Day, Year)
	3 - 0		10-			1)47721		5/12/0	16
1	0		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)	ر ۱ ا	1		
	W		DR. TARIQ MAHMOO		DULANEY VA	LLEY RI	. TIMONIU	M, MD 21	1093	
*	Sta	ate	31. Date filed (Month, Day, Year)	NNA 32 legist	rar's Signature	conti				

1:30 а.ш.

MAY 12, 2006

SHIRLEY AGNELLO

06-03205 Robert C. Bender

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate Registrar	of Death	Reg.	No.		
Physic	ian/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day May 12, 200	ay Year 1245 hrs		
Wedical Exam		Robert C. Bender 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	May 12, 200	4c. County of Death		
		Franklin Square Hospital	Rosedale		Baltimore County		
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours	Min	MM/DD/YYYY) 9. Birthplace (State or Foreign		
Director		264 39 9293	Yrs.	Aug. 23	,1959 Country)Florida		
any		10a. State 10b. County 10c. City, Town or L	ocation		10d, Inside City Limits		
* .	5	Maryland Baltimore Middle	River		1 Yes 2 X No		
Maryl r 28a-í ed at o	Director	10e. Street and Number 29 Chandelle Road	10f. Zip Code 21 220	10g	Citizen of What Country? USA		
with the Maryland ns 23a or 28a-f sho be notified at once.			. Was Decedent of Hispanic Origin?	/ Specify Yes or No-	14. Race - American Indian, Black,		
eath w items	Funeral	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Pu		White, etc		
after d al", or	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: White		
hours natur Exam	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Sb. Kind of Business/Industry				
5-0036 led within 72 hours tygiene. other than "natur the Medical Exam	Completed		center / Cabinet	Maker	Woodworking		
5-0036 Iled within 7 Hygiene. I other than		17. Father's Name (First, Middle, Last) Gerry Bender		lame (First, Middle, Mai			
D 2121 should be fi and Mental I 7 is marked	Be		ailing Address (Street and Number		eming		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is nanyted other than "natural", or items 23a or 28a-f shu interv or other fraumatic event, the Medical Examiner must be notified at once	유	1	- ,		er, Maryland 21220		
G, N I and I Health Fitem		20a Method of Disposition 20b. Place of Di	sposition (Name of cemetery, or other place)		0c. Location - City or Town, State		
MOT Pages nent of ant: 15		I I Bullat Z I A Clemation 3 Removal from State I		4ay 17,2006	Baltimore Maryland		
Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important: It items		21. Unature of Funeral Survice Licenses	22. Name and Address of Facility	Bruzdzinsk	i Funeral Home PA		
Physician	_	23a at I. Enter the disease, or complications that caused the death. Do not en	140/ OLD Eastern ter the mode of dying, such as card	 Avenue Estate iac or respiratory arrest, 	sex Maryland 21221 shock, or heart Approximate Interval		
/Medica		il ire. List only one cause on each line	ssociated with proba		Between Onset and		
Examine	1	or condition resulting in death) Due to (or as a consequence of):					
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated					
xecuted 1 and - fransit							
2 g	/Medical	Xunpended	rME,g856,6/16/06 TT				
760, icate be physically be built			Fetal death 3 Ectopic pr		23d. Date of delivery		
Box 68 e death certif	iciar		Other (Specify)	egnancy	Month Day Year		
cords, P.O. Box 68 law requires that the death certif has been signed by the attending	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown		100 0 111			
P.O. that the ned by	by P		the underlying cause given in Part I		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
ds, I equires een sig	Completed			24a. Was an	24b. Were autopsy findings available		
e law re e has b	l g			autopsy performe			
tal Rection: The	ြပ္မို		26.Place of Death (Ch	1 ✓ Yes 2 neck only one)	No 1 ✓ Yes 2 No		
Vita hysicia this ce	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpa	atient 3 DOA Other N	lursing Home 5 Re	sidence 6 Other:		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by led in the the former of director mass 2 should be detail.	n: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Tim	e of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe hov	v Injury occurred		
Sior Attenc r death ector:	catic	2 Accident Pending Investigation 28e Place of Injury - At home, farm			eet and Number or Rural Route Number, City		
Divi	Certification:	Suicide 6 Could not be determined (Specify)	officer, factory, emice banding, etc.	or Town, Stat			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending Tro the Funeral Director: After this certificate has been signed by the attending the death of the funeral director mass 2 should be deathed for reas	a C						
To the	1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Could						
	Σ	29b. Algnature and title of certifier	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year) May 13, 2006		
		30. Name and address of person who completed cause of death (Item 23a)	J.O.IVI.L.		viay 10, 2000		
		Margarita Korell MD. Assistant Medical Examiner 11					
	State	31. Date filed (Month, Day, Year) MAY 1 6 2006	all				
Reg	strar	MAY 1 6 2006 Magne 15					

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Akilah Yvonne Bodo	1- For State	Department of Certificate of		Hygiene	No
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) AKILAH YVONNE BODDY	<u> </u>		2. Date of Death Month D May 10, 200	3. Time of Death
Luc !	4a. Facility Name (if not institution, give street and number) Amtrack tracks underneath Route 22	4	b. City, Town, or Location of De Aberdeen		4c. County of Death Harford
Funeral Director	5. Social Security Number 6. Sex 7. Ag 18-23-9892 1 M 2XF	e (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	8. Date of Birth (Min. 03/20/1	MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MARYLAND
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on	103/20/1	10d. Inside City Limits
ryland a-f show Lonce.	MARYLAND HARFORD CO 10e. Street and Number	ABER	DEEN 10f. Zip Code	10g	1 Yes 2 No Citizen of What Country?
eath with the Maryland items 23a or 28a-f show ust be notified at once.	13 OSBORN RD		21001		U.S.A.
or death with			s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu		Race - American Indian, Black, White, etc.
ours after attural", c	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com	npleted) 16a. Decedent	Yes 2 XX No specify: 's Usual Occupation (Give kind		Specify: BLACK Sb. Kind of Business/Industry
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Filem 27 is marked other than "natural", or items 23a or 28a-f sho or traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 8	5+) during mo	ost of working life. DO NOT use $ m NT$	retired)	ABERDEEN HIGH SCHOOL
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last) LEON BODDY		18.Mother's N	ame (First, Middle, Maid	
D 212 should b and Men 7 is marl	19a. Informant's Name/Relationship (Type, Print)			or Rural Route Number	r, City or Town, State, Zip Code)
Baltimore, MD 21215 permi. Pages I and 2 should be filed Department of Health and Memal Hy Important: If Nem 27 is marked or injury or other traumatic event, th	Leon Boddy/Father 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Sta	20b. Place of Disposi	tion (Name of cemetery,	Date 2	Oc. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite nijury or other tr	4 Donation 5 Other Specify: 21. Six ature of Fineral Service License.	22. N	ame and Addre of Facility		faure de Grace, Md
ញ់ ឱ្⊴ ≝ ፪ Physician	23a. Part I. Enter the disease, or complications that caused	32	1 S PHILADELPH	IA BLVD, A	
/Medical / Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse				Between Onset and Death
-e	Sequentially list conditions, if any, leading to immediate b				
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse	equence of):		117	
execu an and al - tra	d. UNPENDED AMENDED				
cords, P.O. Box 68760, law requires that the death certificate be has been signed by the attending physici should be detached for use as the burinpleted by Physician/Med	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the past 12 months?		al death 3 Ectopic pre	gnancy	23d. Date of delivery Month Day Year
. Box 6876i he death certificate y the attending phy hed for use as the b	1 Yes 2 No 9 Unknown 4 Pregnant at 9 Unknown	time of death 5 Oth	er (Specify)		1
P.O. Bost that the destruction of detached for by the bost detached for by the by the bost detached for by Phy	Part II. Other significant conditions contributing to death	n but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 V No 3 Probably 4 Unknown
of Vital Records, P.O. ing Physician: The law requires that th Affer this certificate has been signed by wheral director, page 2 should be detach in: To Be Completed by P.				24a. Was an autopsy performe	24b Were autopsy findings available prior to completion of cause of death?
Recate Page	25. Was case referred to medical		26 Place of Death (Che	1 ✓ Yes 2	
on of Vital I lending Physician: auth or: After this certifi the funeral director, ttion: To Be C	Tes 2 No	ent 2 ER/Outpatient		rsing Home 5 Res	sidence 6 🗹 Other Scene
	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation		1 Yes 2 ✓ No	Subject hit by t	train
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	4 Homicide determined (Specify) Rai		t, factory, office building, etc.	or Town, State	et and Number or Rural Route Number, City e) under Rte. 22 Bridge, , MD
To the Hospital within 24 hours a within 24 hours a completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.				
M F S F S	29b. Signature and title of certifier	9 000M	29c. License number O.C.M.E.	1	ad. Date signed (Month, Day, Year) May 11, 2006
	30. Name and address of person who completed bause of d Carol Allan, MD Assistant Medical Exar	,	Street, Baltimore, MD 21	201	
State Registrar	31. Date filed (Month, Day, Year) 32 Registra	r's Signature	R 2		
DHMH 17 Rev 1/2001	MAY 1 6 2006 Meers	ORIGINAL		- ·	

		For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		Reg. N	2111h	15318
Physicia /Medic Examin	al -	1. Decedent's Name (First, Middle, Last, Velence B ta. Facility Name (If not institution, give 1190 W. Northern Park	street and number,			r Location of Death	May 1	2 Year 2 200 (c. County of Death	3. Time of Death 538 PM
Funeral Director		5. Social Security Number 6. Sec		ge (In yrs. last birthday 94 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth 11-11-1911		place (State or Foreigr ntry) INA
Maryland -f show	tor	10a. State 10b. County Maryland N/A		10c. City, Town or L	ocation Utimore				10d. Inside City Limits 1 Yes 2 □ No
h with the 23e or 28e	al Direc	10e. Street and Number 1190 W. Northern PArkv	vay Apt	.324	10f. Zip Code	210		itizen of What Cou	intry?
filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or ttems 23e or 28e-f show ent, I'm Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whit	, etc.
filed within 72 ho Hygiene. sther then "netur ent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 Year's	cation e com <i>pleted)</i> College (1-4or	(Given life.	edent's Usual Occup a kind of work done DO NOT use retired	during most of work d)	ing	Kind of Business/li	
should be filed and Mental Hyg s marked othe umetic event,	To Be C	17. Father's Name (First, Middle, Last) Floyd Boyd				18. Mother's Nam	e (First, Middle, Maide lates al Route Number, City		in Codel
l and 2 lealth a im 27 ls		19a. Informant's Name/Relationship (T) ROSE Provenzano - Niec 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ F	ce	20b. Place of Disp) W. Notherr osition (Name of ematory or other place	Parkway	Baltimore, M	aryland 212 Location - City or T	210 Town, State
permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other to 000s.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Poneral Service Licens		finer 2	2. Name and Addre	ss of Facility	7/2006 1305 Harford		more, MD
Pnysician /Medical		23a. Part 1. Epter the disease, or comp shock, otheart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each	line.	ter the mode of dyin		or respiratory arrest,		Approximate Interval Between Onset and Death
Examiner sian and urial-transit	i Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	s a consequence of):					
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ū No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc	y		23d. Date of deliment	very Day Year
requires that the een signed by th hould be detache	d by Pr	Part II. Other significant conditions co Dementia of the	_	but not resulting in the		ven in Part I.		use contribute to	the cause of death?
The law rec cate has bee page 2 shou	Complete	,			1 }		24a. Was an autopsy performed?	prior to c death?	opsy findings availab ompletion of cause of 2 \(\text{No} \)
Attending Physicien: The laver death. Fector: After this certificate has by the funeral director, page 2.	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpat	iury 28b. Time	of 28c. Injui	ner: 4 Nursing Ho	h (Check only one) ome Residence 28d. Describe how in	6 Other (Speciary occurred	ify)
el or Atte s after des el Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of le building, e	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Street City or Town, Sta		ral Route Number,
To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medical Exam		st of my knowledge, dea of examination and/or stated.	nvestigation, in my o	opinion, death occur	red at the time, date a	nd place, and due	to the cause(s)
	M	29b. Signature and title of certifier Curry Diff. 30. Name and address of person who certifier	open HW		29c. Licens D 3 (29d. C Ma	Date signed (Month	
10×1	to		enthal, v	M.D. 3414	4	of Street	Bull-m	DE MD	21218
Regist		MAY 1 6 20	201	no the A	mil				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 14, ^{Day}2006 **Physician** Elizabeth M. Binko 1:35 a[™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Future Care-Canton Harbor Baltimore Months Days Hours Min. A ug 37, Year 920 Mary and 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** 1 M 2 F 85 217-09-1569 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code ö 21222 USA 1649 Manor Road Itame 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other treumatic event 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marth Orlinowski Stephen Slowik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Theresa Ave Balto. MD 21221 19a. Informant's Name/Relationship (Type, Print) Debi J. McCluskey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 05/16/06 Baltimore MD 5 ☐ Other (Specify) ¹ 4 ☐ Donation of Funeral service lense 22. Name and Address of Facility 300 Mace Ave Balto MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examiner use as the burial-transit certificate be executed Cause (Disease or injur that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 🗌 Yes 2 □ 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes 2 No 1 ☐ Yes 0 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2000 Hospital: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Doath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attanding 24 hours efter death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated tha To the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and tife of certifier 29c. License number 276 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon Scalia 2801 Hudson Street Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Region Is Sported MAY 1 6 2006

DHMH 17 Rev 1/2001

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			For State Ragistrar	State of Marylar		artment of F rtificate of		_	ene g. No 2006	15320
H	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month May 16	Day Year	3. Time of Death 5:35 a M
		/Medical Doris Berdine **Examiner** 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Deatl	
	Examin	er	Ivy Hall Nursing			Essex			Baltimore	
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	Hrs. 8. Date of Birth 9. Birthplece (State or Foreign		
-	Director		235–16–3575	^{□ M 2} MF 88	Yrs.	Months Days	Hours Min.	Sept. 30,	1917 Ka	nsas
	D.		Usual Residence of Decedent							
	how		Md. 10b. County Baltin		ity, Town or Lo Dunda					10d. Inside City Limits 1 ☐ Yes 2 X No
	filed within 72 hours after death with the Maryland Hygiene. Riber then "natural", or items 23e or 28e-f show ent, the Madical Examirer must be notified at	ct	Md. Balti	IOLE	Durida.					
		To Be Completed by Funeral Director	10e. Street and Number			10f. Zip Code	24222	10	g. Citizen of What Co	untry?
215-0036	ath w		2606 Plainfield				21222		USA	
	n 72 hours atter death with the Marylan "natural", or items 23e or 28e-1 show adical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 [X] No if Yes, Give Year or Dates:		Was Decedent of F If Yes, specify Cub. 1 ☐ Yes 2 XNo	tispanic Origin? (Sp an, Mexican, Puerto Specity:	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Ď	2 ho		15. Decedent's Edu	dent's Usual Occup	s Usual Occupation 16b. of work done during most of working IOT use retired)			. Kind of Business/Industry		
212	Mad		(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	arry		
2	gien and and and and and and and and and an		12 yrs.		Hous	sewife			Home	
2	should be filed within 72 ho id Mental Hygiene. marked other then "natur matic event, the Madical		17. Father's Name (First, Middle, Last)					e (First, Middle, N		
<u>a</u>			J. M. Bond				Anna G	. Spillm	an	
Maryland 21	2 2 2 2		19a. Informant's Name/Relationship (T						City or Town, State, Z	ip Code)
	1 end 2 Health iem 27		Wilma J. Alders		2000		eld Rd. D			
ore	A O		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 1	Removal from State	Place of Dispo cemetery, cre	osition (Name of matory or other pla	_{сө)} Мау	20	0c. Location - City or	Town, State
Ĕ	Pages nent of ant: If it ury or o		4 □Donation 5 □Other (Specify,		Oak Lav	wn Cem.	1		Baltimore	
Baltimore,	permit. Page Department of important: If eny injury or once.		21. Signature of Figheral Service Ligensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222							
	Physician /Medical Examiner		23a. Party Enter the disease, or comp	lications that caused the dea						Approximate Interval Between
			shock, or heart failure. List only of immediate Cause (Final	ne cause on each line.		110				Onset and Death
			disease or condition resulting in death)	a. Due to (or as a consé	Demontia Due to (or as a consequence of): 3 year					8 years
				5 to (or as a consequence or).					•	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. Una to (or as a consequence of):						
		Examiner	Cause (Disease or injury that initiated events							
ó	ficate be executed physicien and is the burial-transit		resulting in death) Last	Due to (or as a conse	consequence of):					
68760,	icate be executed physicien and s the burial-transit	Physician/Medical		1						
_	tifica og ph as th									
Вох	The law requires that the death certifi te hes been signed by the attending age 2 should be detached for use as		230. was decedent pregnant	l3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy				23d. Date of delivery		
o. D	deat le att	200	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐ Pregnant at time of death 5☐ Other (specify)				Month Day Year	
P.O.	by the	hys	9 Unknown							
	res that the de signed by the a be detached f	by	Part II. Other significant conditions co	, 1	esulting in the u	underlying cause giv	ven in Part I.		acco use contribute to	
ğ	w require been si should b	ed	Fai	lure to	thri	10		1 🗀 Ye	s 2.21No 3 ☐ Pro	obably 4 Unknown
ည် ပ	he law re hes be ge 2 sho	Completed						24a. Was ar autopsy	24b. Were au	topsy findings available completion of cause of
č	The ste he	E						perform	ed? death?	2□ No
ā	riffice tor.	25. Was case referred to medical 26. Place of Death (Check only one)								
2	ysici is cer direc	TOE	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
0	ig Ph ter th neral	27. Matural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 28d. Describe how injury occurred Work? 1 Pending investigation								
<u></u>	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page									
Division of Vital Records,		edical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street an City or Town, State				ral Route Number,		
_			29a. Certifier (Check only (Check only 2) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
	thin 2 the the	Med	one)	and manner stated.		29c Licens	se number	90	ld. Date signed (Mont)	n. Dev. Year)
•	5 ¥ C p		29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29						d. Date signed (Month, Dey, Year)	
'	d		-				2799	·	17175 16	2006
h	V		30. Name and address of person who	1 10 11		, Print)	2.4.		4D. 21) '2 (
5			31. Date filed (Month, Day, Year)	32. Registrar's Sign	ace /	Tro, 10	a (V) me	reil	11/1/1	
	Sta Regist		MAY 1 6 2006		Ana	des				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ¿ 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11, 10:45 pm 2006 Edwin William Balcer May /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins - Bayview Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1**∑**M 2□F 82 215-18-6692 Yrs. June 29. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits * show r then "naturel", or iteme 23a or 28a-f shov the Medical Examiner fount be notified at 1X Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 6706 Roberts Avenue USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Electrician Bethlehem Steel 12 years permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygin Important: if item 27 is marked or eny Injury or other from 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Josephine Dabrowski Chester Balcer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Balcer wife 10 Township Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cemetery 20c. Location - City or Town, State 20a. Method of Disposition May 17, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, MD. Donation 5, Other (Specify) ture of Jun ral Service Sign 22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Approximate Interval Between Onset and Death Inter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomy opat Dilated years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ponknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 🗌 No Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21/2 010001 31. Date filed (Month, Day, Year) MAY 1 6 3 Registrar's Signature State 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Dongiovanni MAN Dne 2006 /Medical 4a. Facility Name (I not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silchris DALTIMORE (enter 10WSOR Il Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 Days 236.42 75 Yrs. Director Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MM HARFOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1003 B sicas Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No Il Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. Completed by 3 Widowed 4 □ Divorced white Bongiovanni, Betty 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ames Hugha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City)or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 la any injury or other trat once. BALDWIN David 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/18/06 Mocelana ' 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE MI 22. Name and Address of Facility FOREST 21. Signature of Funeral Service Licensee HILL, MO 21050 EVANS FUNEKAL CHAPEL 3 NEWPORT DR 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Light only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastanc **Physician** neeyoendocuro months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-t Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) HDS, DICE 1 Yes 2 Yo 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

am

32 Registrar's Signature

M Garden

6 2006

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31. Date filed (Month, Day, Year)

D00519260

TOWSON, MD

6601 N. CHARLES STREET

May 14, 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Bradu 8:269M **Physician** 05 10 2006 /Medical C County of Deeth 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Chase Nursing Home If Under 1 Year 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 2**X**F Days South Carolina 374-38-7608 77 Yrs. Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-1 show traumatic event, the Medical Examinar result be notified at Baltimore Owingsmills 1 ☐ Yes 2 No MD Director 10e. Street end Number 10g. Citizen of What Country? 104 Pleasantridge Drive U.S. 21117 permit. Pages 1 end 2 should be fliad within 72 hours after death v Depertment of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural" ~ "- any injury or other traumatic events. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 22No Specify. Specify: Black ğ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Certified Nursing Asst. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Private Dute Coltege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jones Hampton Duise Juncan 19a. Informant's Name/Relationship (Type, Print) Dauanter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 8543 Paragon Court Upper Marl boro MO 20772 Date 20c. Location - City or Town, State Anderson Maria 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5-17-06 Crownsville, MD Lrownsville Veterans Donation 5 Other (Specify) tur of Funeral Service Licen ee Vaughn C. Greene Funeral Services 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital or Attending Physician: The law requires that the death certificate ba executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physi within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral dir

				1 □ Yes 2 1 10	3 Probably 4 ☐ Unknow				
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?				
05 111					10 165 20 110				
25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Menne of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 Suicide 6 Could not b determined	286. Place of injury - At r	Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
				e, and due to the cause(s) and m surred at the time, date and place,					
29b. Signature end title of certifier	Λ	2	29c. License number	29d. Date signe	ed (Month, Day, Yeer)				

Registrar

led (Month, Day, Year) State

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pleted cause of deeth (Item 23e) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year JOHN CHARLES BOWERS May 2006 14 /Medical 5:46 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Greater Baltimore Medical Center Towson
II Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign X X M 2□ F Days Hours Min. August 5° 1929 Mary and 214-26-9864 76 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or iteme 23a or 28a-f ahov 10d. Inside City Limits the Medical Examiner rivet be notified at Director Maryland Baltimore Baltimore 1 ☐ Yes X XX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6647 Walnutwood Circle 21212 USA Completed by Funeral 12. Was Decedent Ever in U.S. Agreed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2XXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced "neturel", Baltimore, Maryland 21215-00; 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Importent: If tem 27 is marked other than eny injury or other treumation. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Adolph Bowers Leona Head 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6647 Walnutwood Circle Baltimore, Maryland 21212 Maryann Bowers Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State GreenMount Cemetery 4 💋 Donation 5 Other (Specify) 5/16/06 Baltimore, Maryland nature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably I Director: After this certificate has d in by the funeral director, page 2 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funerel Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Mo State Registrar

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			State of Maryland /		irtment of H		, ,	201	16	15325
- 53	k. 20 - 64-7	-	Registrar 1. Decedent's Name (First, Middle, Last)		inouto or E	Journ	2. Date of Dea	leg. No(U		3. Time of Death
	Physici	an	AUDREY NELLIE BOONE				Month	12, 20	Year 76	9:20 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	May	4c. County		
	EXCITITE	ier	Gilchrist		Towso	n		Ra1	timo	ore
40	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Foreign ntry)
£,	Director	4	212-26-9011 1 M 2X F 82	Yrs.	Months Days	Hours Min.	June 19	1923		ÿland
3987	۶ .		Usual Residence of Decedent							
	larylan show	_	10a. State 10b. County 10c. City, To	own or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 XNo
	or 28a-f	cto	Maryland Baltimore Town	son						
	vith th	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Cou	ntry?
	e 23a	ral	609 Fairway Drive	10.1		21286	anifu Van au Na	U.S		can Indian,
	ter deal	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	13. 4	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		, White,	
36	rs att	by F	3 Widowed 4 Divorced Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	Whi	to
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212	e filed within Il Hygiene. other than vent, Ire M.	E		r. Ac	counting	Clerk		Board of	Ed	ucation
٦	be filed within 72 hours atter death with the Maryland tal Hygiene. d other than "natural", or Iteme 23a or 28a-f show orent, the Madical Examinat must be mailliad at	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name				
<u> a</u>	Alenta Alenta Alenta riked	ToE	Robert Gooch			Adeline	Martha	Schule	er	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours atter death with the Maryla f Health and Mental Hygiene 1 ftem 27 is marked other than "natural", or Itema 23a or 28e-f show other traumatic event, I'm Madical Examinar must be multified at		19a. Informant's Name/Relationship (Type, Print)	9b. Mailin	g Address (Street a	nd Number or Rura	al Route Numbe	r, City or Town, S	state, Zij	Code)
	and 2 palth 127 i		Theresa Murphy (daughter)	504 S	Sussex Roa	ad Towson	n, Maryl	and 212	86	
ore	/h ()		20a Method of Disposition 20b. Place	of Dispos	sition (Name of natory or other place		Date	20c. Location - (own, State
Ĕ	Pages nent of l ant: If its		4 Donation 5 Other (Specify)	ville	Veterans C	em. 5-15	-06	Crownsvi	.11e	Maryland
Baltimore,	permit. Page Depertment (important: If any Injury or once.		21. Signature of Funeral Service Licensee	22 M	Name and Addres litchell- 6500 Yorl	s of Facility Viedefeld	Funera	1 Home,	Inc	
			23a. Part1. Enter the disease, or complications that caused he death. D	not ente	obuu York	KOAO B	altimor	e, Marýl	and	21212 Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final			T.		631,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	e 1	Leuke	mil	7			menter
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J	ted nsit	ul.	cause. Enter Underlying Cause (Disease or injury							
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0/AN 8760	sate be executed physician and the burial-transit	dical	d							
		edic	V.							
2 ×	The law requires that the death certific Ite has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		le .			23d. Date	of deliv	ery
, m	death e atte	icia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		Ectopic pregnancy Other (specify)			Mon	th	Day Year
30	that the de ed by the detached	hys	9 ☐ Unknown 9 ☐ Unknown							
2/2	es tha igned be del	y P	Part II. Other significant conditions contributing to death but not resulting	g in the ur	iderlying cause give	n in Part I.	23e. Did to	bacco use contri	bute to th	he cause of death?
5/s	v require been sig should b						1 🗆 Y	es 2. No	3 ☐ Prot	pably 4 □Unknown
000	law requas been 2 shoul	Completed					24a. Was a	n 24b. W	ere auto	opsy findings available impletion of cause of
259 R	The tage has	E					autop perfor 1 Yes	med? de	ath?	2 No
		Be C	25. Was case referred to medical			26. Place of Death				
\$ >	S S D	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatien	3□ DOA Othe	T: 4 Nursing Ho	me 5 Resid	ence 6 Othe	r (Specii	W HOSPICE
			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	o. Time of Injury	28c. Injury Work			ow injury occurre		
3 0	Attending r death. sctor: After y the fune	atlo	2 Accident investigation			′es 2□No				
Second	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rura	al Route Number,
20	ital o rrs at ral D									
	To the Hospital or At within 24 hours atter of To the Funeral Direct completely tilled in by	edical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowled and manner stated. Limit Certifying Physician: To the best of my knowled and manner stated. Limit Certifying Physician: To the best of my knowled and manner stated.	dge, death and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occurr	and due to the or ed at the time, or	ause(s) and mar late and place, a	ner as s nd due ti	tated. the cause(s)
	To the within 2 To the complet	₹ E	29b. Signature and title of pertifier		29c. License	number	Z	9d. Date signed	(Month,	Day, Year)
	,		Ill Hothers Male on	W	02:	5205		MAY	12	, 2006
	h		30. Name and address of person who completed cause of death (Item 23:	a) (Type, I	-	N. CHAR	LES ST	CEET		
	E.		21 Date filed (Abouth Day York)		100	VSON, M	ND CI	204		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2006 Registrar's Signature	Low	er.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Yanity 4 Shirley Bloom Thomas 7:00 A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Living Pikesville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🕱 F 213-32-8095 69 Hours Director August 08 1936 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Be Completed by Funeral Director Maryland Baltimore Pikesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 805 Silver Creek Road 21208 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Itsm 27 is marked other t any injury or other treumatic event, in once. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald L. Norma Norfolk ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cheryl B. McRaney (Daughter) 3204 Chestnut Avenue, Baltimore, Maryland 21211 20a. Method of Disposition

1 Aurial 2 Cremation 3 Removal from State 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Cedar Hill Cemetery 05/15/06 Baltimore, MD. 21225 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 00 8728 Liberty Road, Randallstown, Maryland 21133 23a. First 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** >10~ /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed page 22 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1_Natural 5 Pending after death.

Director: Af
d in by the fur investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L filled Letitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Criosser 31. Date fifed (Month, Day, Year) State Assart Registrar 6 2006

			1 - For State Registrar	State of Ma		epartme Certifica			Mental Hy	giene 2	006	15327
			1. Decedent's Name (First, Middle, Last)						2. Date of D	eath	V	3. Time of Death
	Physici /Medic		Charles W. Burke	У					May 10	Day 2006	Year	0630 M
je.	Examin		4a. Facility Name (If not institution, give s	•				Location of Deat	h	4c. Cou	nty of Death	
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1	Funeral		5. Social Security Number 6. Sex	(M 2□F /. Age	(In yrs. last birth	rs. Month	der 1 Year s Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D	ay, Year)	Cou	place (State or Foreign intry)
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	or 28	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen	of What Cou	ntry?
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Maryland	2 2 2 2		19a. Informant's Name/Relationship (Type					and Number or Ru				20030
	s 1 and of Health Item 27 other tr		Fatima Solomon/Wi 20a. Method of Disposition	fe	91 20b. Place of 0			Champion	Drive,		-	
وّ			1 XXurial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery	crematory of te	r other place	^{a)} ¦ May	16,	20c. Locatio		
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<u>ö</u>	ath. or: Aff	atlo	1 XiNatural 5 ☐ Pending 2 ☐ Accident investigation	(worm, bay		ury M		es 2 □ No				
DIVISION	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm	n, street, facto	ory, office		28f. Location (City or To		nber or Rura	al Routa Number,
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	To the Hospital or Attending Ph within 24 hours alter death. To the Funeral Director: Aller th completely filled in by the funeral	edlcal	29a. Certifier 1 X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	xamination and/	death occurre or investigation	ed at the time on, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			2	9c. License			29d. Date sign	ned (Month,	Day, Year)
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	cate be executed physicien and the burial-transit	dicail		d									
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5	The law requires that the death certil ete has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregn birth 2 ☐ Fet	ancy aldeath 3	Ectopic pr	egnancy			1	ate of delive	,
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	To the Hospital or Attending Physician: within 24 hours after death To the Funaral Director: After this certific completely filled in by the funeral director.	Med	29b. Signature and title of certifie		nner stated.		290	. License	number		29d. Date sign	ed (Month.	Day, Year)
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	06		30 Name and address of person	who completed car	use of death (Ite	m 23a) (Type.	Print)			-			
	7		ASINTAN FO	ARAHIFA	RM.D	9801	Geo	gia	Ave Sui	1 3-41	Silver	prin	MD 20902
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	Registi	rar	ווירו ד (2000	PRINT A	OF Dos	3000						

Amenditen#16a,17,perFH, \$35,5,2200 TI State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Katherine B. Cornett May 13. 2006 7:31AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fenwick Landing Assisted Living Waldorf Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb. 18,1916 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🙀 F 90 022-03-3548 MA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Eraninar must be notified at Maryland Charles Waldorf 1 ☐ Yes 2X No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11655 Doolittle Drive 20602 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: If Yes, Give Year or Dates: Completed by 3 X Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DQ NOT use retired) Cashier 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 le marked other f 12th Casher Retail 17. Father's Name (First, Middle, Last) Konderwicz 18. Mother's Name (First, Middle, Maiden Sumame) Be Jacob Kenderwicz Helen Turko other traumatic ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Colbert (Daughter) Department of Health Important: If item 27 24368 Asbury Drive Denton, Maryland 21629 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State May 17, ō * 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. d Veterans Cem. 2006 Cheltenham,
22. Name and Address of Facility Lee Funeral Home, Inc. Cheltenham, Maryland 21. Signature of Funeral Service Licensee any ir ta D. July 6633 Old Alexandria Ferry Road Clinton, MD 20735 m01284 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** e 6) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 🗆 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Bknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 Yes 2⊟No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASS - LIVING 2 1 🗌 Yes 312 40 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD 0 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006

Balti	permit. Departm
	Physicia /Medic Examin
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicien and complately filled in by the funeral director, bene 2 should be defacthed for use as the burial-transit

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		-	For State Registrar		•	rtificate					Reg. No.	2006	15330
	Physici	an	Decedent's Name (First, Middle, Last) Theodore	C	hapman					2. Date of Dea Month 13	D	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give :			4b. City,	Town, or	Location of	of Death	1144 15		County of Deal	13:50 M
	Examin	er	Fort Washington					ashin	gton		Pr	ince G	eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) 95 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	B. Date of Birt (Month, Day Aug 14,	h y. Ye <i>ar)</i> 191	9. Bird	hplace (State or Foreign
	Director		577 22 7349 Usual Residence of Decedent							iug 14,	191	O NO	rth Carolina
	anylan	7	10a. State 10b. County		c. City, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the Mi	Director	Maryland Prince G	eorge's	Fort Wa	Shing 10f. Zip					10g. Citiz	en of What Co	
	72 hours after death with the Maryland natural", or itema 23a or 28a-f ahow Jicul Exaria ar must be i cuttled at	a D	10804 Livi	ngston Road			207	44			U	nited S	States
	tema tema	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces?		Was Deced If Yes, spec	lent of Hi rify Cuba	ispanic Ori n, Mexicar	gin? (Spec n, Puerto R	ify Yes or No- lican, etc.)	. 1	 Race - Ame Black, Whit 	
36	urs afte	by F	1 ☐ Never Married 21_4Marned 3 ☐ Widowed 4 ☐ Divorced	1\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	WWII	1 ☐ Yes	XX No	Specify:				Specify:	White
2-0	72 hor	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usua kind of wor	d Occupa	ation du <i>ring</i> mos	t of workin	g	16b. Kir	d of Business	Industry
121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		am Fi)			Un	. of Ma	aryland
d 2	e filed al Hygi other vent, I	Be Completed by	17. Father's Name (First, Middle, Last)					18. Mothe		(First, Middle,		Su <i>mame)</i>	
ylai	ould b	To	Peter Chapma		dob Marili		/Care at a	and Aluma ba		nnie Br		Town, State, 2	Zin Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 a marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Mudical Exercities in that be rediffied at 20cc.		19a. Informant's Name/Relationship (Ty Terry Chapman (So		1							ket. MI	
Baltimore,	of Hea of Hea fitam rothe	1 12	20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ F	21	Ob. Place of Dispo cemetery, cre						20c. Loc	ation - City or	Town, State
tim	tment tent: I	1	4 □ Donation 5 □ Other (Specify)		Maryland								n, Maryland
Bai	Depar Impor any Ir		21. Signatura of Funeral Service Licens	mooas7						Funera ad, Cl			663301d 20735
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the ne cause on each line.	death. Do not en						rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	2 DIAL		NF	ALC	1101	<u> </u>			
	Examiner		Sequentially list conditions).	naoquoriso sij.								
,	pe usis	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):								
/_	le be executed ysicien and e burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a con	nsequence of):								
3760,	ate be hysicle the bur	cal		J									
89 X	eath certificate t attending physi i for use as the b	/Mec	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr	egnancy						2	3d. Date of de	livery
Box	0 0 0	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ 4 Pregnant at time 9 Unknown		⊒Ectopic pr ⊒ Other (sp						Month	Day Year
P.0	ac by		9 ☐ Unknown Part II. Other significant conditions con		at resulting in the u	ınderivina c	ause div	en in Part I		23e. Did to	obacco us	se contribute to	the cause of death?
Division of Vital Records,	S	Completed by	ATHEROSCLERO	TIC CAR	-DIOVA	CUL	ML	Dus	EASE	101	/es 2□]No 3∏Pr	obably 4 Onknown
OOE		plete	200 81							24a. Was	sv	24b. Were au	utopsy findings available completion of cause of
Ä	The ete h pege	Сош								1 ☐ Yes	rmed? 2 No	death?	2 □ No
Vita	Physicien: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	lospital:	2 ☐ ER/Outpatie	nt 3 DO	Oth			(Check only o		☐Other (Spe	cuty)
n of	ding Phys h. After this funeral di	n: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yes	28b. Time o		8c. Injun			Bd. Describe			y)
sion	Attanding r death. ector: After by the fune	catlc	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home form at	М	1 🗆	Yes 2 🗆		Af Location (Street and	Number or Ri	ural Route Number,
Divi	after after I Direct of in by	Certification:	4 Homicide determined	building, etc. (S	pecify)	reet, ractory	, onica			City or Tov	vn, State)	rranibor Gran	3.3.77646674477,207,
	To the Hospital or Attandli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		sician: To the best of my ner: On the basis of exa and manner stated.									
	To th within To th compi	Me	29b. Signature and title of certifier	PHYSICIA	N	290	~	3 7	82			signed (Mont	h, Day, Year)
	140		30. Name and address of person who co		(Item 23a) (Type		DAD	Line	TE#	iol F	t. 1	Al Assi Ini	G TON, MD
	Sta	te	SULESH VERGHESE 31. Date filed (Month, Day, Year)	OO Desistanda (Cimantura			301	π			411011114	
8	Regist		MAY 1 6	2006 Legeral	w B.	GOOM							
DH	IMH 17 Rev 1/2	001	****	and the same of th									

			For State Registrar	State of	Marylan	-	artment o	f Health a of Death			giene Reg. No.	006	15331
	Physici	_	Decedent's Name (First, Middle Ralph	B.		Co11:	ins			2. Date of De Month May 9	ath Day 200	6 Year	3. Time of Death 6:10PM M
	/Medic Examin		4a. Facility Name (If not institution Southern Mary 1				4b. City, Tow	n, or Location o	ton		4c. Co Pr	ounty of Death	eorge's
	Funeral Director		5. Social Security Number 579-30-2621 Usual Residence of Decedent		7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Birt (Month, Da Jan 2	9,192	9. Birth Cou Was	place (State or Foreign http). Shington DC
	he Maryland 18a-f show	ector	10a. State 10b. County Maryland Princ 10e. Street and Number	e George's		y, Town or Lo	Forestv				10- Citi-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23s or 2 lattern	al Dir	3406 Springdal	e Avenue			10f. Zip Coo 20	747			-	n of What Cou	ntry !
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it is Midical Examinar must be multiled at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 2 Married 4 Divorced	16 Van Chie	es? 2□No 195	52-	Was Decedent If Yes, specify (1 ☐ Yes 2 ☐	of Hispanic Ori Cuban, Mexican No Specify:		cify Yes or No Rican, etc.)		Race - Ameri Black, White, pecify: Whit	etc.
Maryland 21215-0036	d within 72 ho giene. er than "natu	Completed by	15. Deceden (Specify only highe Elementary/Secondary (0-12) 8th	t's Education st grade completed) College (1-	4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re Lumber	one during mos	t of workir	ng		of Business/ir	
and	d be file antal Hy ced othe c event,	To Be C	17. Father's Name (First, Middle, Albert	Last) Collin	S					(First, Middle, Unkno		ımame)	
Mary	nd 2 shoul lith and Me 27 ie mark r traumati	Ĕ	19a. Informant's Name/Relations Anita M. McGr		ghter)			reet and Number	er or Rura	l Route Numbe	er, City or T		code)
Baltimore,	Pages 1 are neut of Hear int: if item iry or othe		20a. Mathod of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S			cemetery, crei	osition (Name of matory or other Vetera:	f place) ns Cem.	May 200	19, 06		tion - City or T enham,	own, State Maryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service		31284			ddress of Facility d Alexa					on, MD 20735
68760,	Physician /Medical Examiner	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence o		25	From	י) ספרי המשרים	5-P	Rober	able	Onset and Death
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta int at time of d	al death 3	□Ectopic pregn □ Other (s <i>pecif</i>)				230	d. Date of deliv	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditi									contribute to	he cause of death?
Division of Vital Records,	: The law re cate has ber , page 2 sho	Completed	10/1,tus	, Rear						24a. Was auto perfo 1 🗆 Yes		prior to co death?	opsy findings available impletion of cause of
f Vita	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatie	nt 3 DOA	Othor		(Check only only only only only only only only		□Other (Speci	fy)
o uois	ending Ph eath. or: After th he funeral			gation	f Injury n, Day Year)	28b. Time o Injury		Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe	how injury o	occurred	
Divis	tal or Attend rs after death el Director: /	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place	of Injury - At h g, etc. (Specii	ome, farm, st	reet, factory, of	fice	2	28f. Location (City or To		Number or Rur	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier VX Certifyi (Check only 2 Medical one)	ng Physician: To the Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the occurred at	ne time, date ar my opinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
	with Com	×	29b. Signature and title of certifie		>,~	D		063998				signed (Month.	
	1011		30. Name and address of person Manesh Nachna					nton MD	207	735			
79 - S	Sta Regist	ate rar	31. Date filed (Month, Day, Year MAY 1	6 2006 32. Re	gistrar's Signa	ature	(code)						

			For State Registrar		State	of Marylar		artment rtificate			and M		giene Reg. No.	006	153	32
	Dhysisi	۹.	1. Decedent's Name ((First, Middle, La	ist)							2. Date of Dea Month	ath Day	Year	3. Time of	Death
b.	Physici /Medic		Freddie									05	09	06	5:55	A M
1	Examin	ęr	4a. Fecility Name (If n 2712 Urba	_		mber)		4b. City, T						ounty of Death		
4.	#I	v	5. Sociel Security Nun		/e Sex	7. Age (In yrs.	last highday	If Under 1		Sprin	_	8. Date of Birt		lontgom		. Farain-
	Funeral Director				1 M 2 🗓 F	7. Age (111 yrs.	Yrs.		Days	Hours	Min.	(Month, Day	r, Year)		place (State o	r Foreign
(8%	_		579-30-02 Usual Residence of D									09 22		Geor	gia	
	arylan show	_		10b. County			ty, Town or Lo								10d. Inside Ci	
	Ba-f s	ecto		Prince (Georges	D	lstrict								1Ž∏ Yes	
	with []	Dire	1953 Add		had			10f. Zip 0					_	in of What Cou SA	intry?	
	eath	Funeral Director	11. Marital Status	arson Re		edent Ever in U	J.S. 13.	Was Decede	ent of His	spanic Orio	nin? (Spe	city Yes or No-		. Race - Amer	ican Indian.	
(0	after d	Fun	1 Never Married	d 2 Married	Armed F 1 ☐ Yes	orces? 2. ⊠No		If Yes, specif	fy Cubar	n, Mexican	, Puèrto I	Rican, etc.)		Black, White	, etc.	
ğ	ral', o	d by	3X Widowed 4	Divorced	If Yes, G Year or I	ove Dates:		1 ☐ Yes 2	XI No	Specify:			S	pecify: Bla	ck	
21215-0036	within 72 hours after death with the Maryland one. Than "natural", or Items 23s or 28s-f show he Medical Examinar must be nutified at	Completed		5. Decedent's E only highest gr			(Give	dent's Usual kind of work	done di	uring most	of working	ng	16b. Kind	of Business/la	ndustry	
2	withir ene. than	dmo	Elementary/Second		College (1-4or 5+)		DO NOT use	reurea)				II 0	0		
0	filed Hygi other ant,	C	12th 17. Father's Name (F)		t)		L LAI	orer		18. Mothe	r's Name	(First, Middle,		Gover	nment	
Jan	t should be fited wand Mental Hygie s marked other thumatic avant, the	To Be	Isaac K	ent						TEss	sie 1	Frierso	n			
Maryland	2 should be filed within 72 hours after death with the Marylan and Manthal Hygiene. Is marked other than "natural", or Items 23s or 28a-1 show aumatic avant. The Madical Examinar must be rediffed at		19a. Informant's Nam	•			19b. Mailir	ng Address (Street a	nd Numbe	r or Rura	i Route Numbe	r, City or 7	own, State, Zi	p Code)	
Σ,	and 2		Roberta R		z/Daught							Spring				
altimore,	ges 1 f of H if iten		20a. Method of Dispo		Removal from	JIAIO	Place of Dispo cemetery, crei	_	-			ate		tion - City or T		
Ē	t. Pa tmen tant: ijury		° 4 □ Donation 5			Ha	rmony 1			1	5-13-			ver, M		
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		21. Signature of Fune	eral Service Lice	, 12 - 8	20						shall's				
			23a. Papil Enterthe	disease, or con	nplications that	caused the dea						Washin		, D.C.	Approximate	3
			Immediate Cause (Fi	failure. List only inal											Onset and D	veen Jeath
	Pnysician /Medical		disease or condition resulting in death)			ladder (or as a consec										
ř.	Examiner		Sequentially list cond	titions	b											
	Ag is	iner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	nediate ying		(or as a consec	quence of):									
V	xecute and Il-tran	Examiner	that initiated events resulting in death) La		c	(or as a consec	uence of):									
760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit			•	d											
89	ifficate g phy as the	Physician/Medical														
Вох	es that the death certific igned by the attending p be detached for use as	an/N	IF FEMALE: 23b. Was decedent p			itcome of pregn		Ectopic pre	gnancy				230	d. Date of deliv	*	
O.	e dea the att	sici	in the past 12 m 1 ☐ Yes 2 🔯 I 9 ☐ Unknown			nant at time of o		Other (spec			-			Month	Day Y	'ear
<u>م</u>	hat th id by 1 detach	Phy	Part II. Other signific	ant conditions	contributing to a	leath but not res	sulting in the u	nderlying car	ise aive	n in Part I		23e. Did to	bacco use	contribute to	he cause of de	eath?
Records,	signe d be c	d by		obility	oonting to	Journal Total	January III (III) a	ndonying oat	aso givo	irarranti.				No 3 □ Pro		
COL	w require been sign should b	Completed	Mor	bid Obe	city							24a. Was a	an :	24b. Were auto	posv findings a	vailable
Re	The lay	omp										autop: perfor	med?	24b. Were auto prior to co death? 1 Yes	mpletion of ca	use of
Vital	ysician: The is certificate hi director, page	a)	25. Was case referre	pertensi d to medical	on					26. Place	of Death	1 Yes	2 No 1e)	T Tes	2 L NO	
>	Physici this cer al direc	To B	examiner? 1 □ Yes 2 □ N	0	Hospital: 1	Inpatient 2	ER/Outpatier	it 3□ DQA	Othe	r: 4 🗆 Nur	rsing Hon	ne 5□Resid	ence 6≸	Other (Speci	Daught	ers
0			27. Manner of Death 1 X Natural	5 Pending	28a. Date (Mor	of Injury hth, Day Year)	28b. Time of Injury		c. Injury Work	at ?	2	28d. Describe h		occurred	* DOME	
<u>s</u>	Attanding or death. ector: After by the funer	catl	2 Accident 3 Suicide	investigation	20	41-1		М		es 2□N	-	104 Laureign 40	4			
Division of		ertification;	4 Homicide	determined	build	e of Injury - At h ling, etc. (Speci	ome, tarm, str fy)	eet, ractory,	Office		2	8f. Location (S City or Tow		vumber or Hur	ai Moute Numt	ier,
	Hospital	O	29a. Certifier 1	☑ Certifying P	hysician: To th	e best of my kno	owledge, deatl	n occurred at	t the time	e, date and	d place, a	and due to the c	ause(s) ar	nd manner as s	stated.	
	To tha Hospital or within 24 hours after To tha Funaral Dir completely filled in	edical	(Check only 2 one)	Medical Exa	miner: On the t and mar	pasis of examination	ation and/or in	vestigation, i	n my op	inion, deat	h occurre	ed at the time, o	late and pl	ace, and due t	o the cause(s)	
	To the track to th	Σ	29b. Signature apotit	tle of certifier		10/	///	, 29c.	License	number		2	9d. Date s	signed (Month,	Day, Year)	
			1///	MA	FOR T	CER	1///	D32	2923			0	5-10-	-06		
	1		30. Name and address				Type,	Print)					_0	50		
Į.	Sta	to	Dr. Melise	Fried	lland, M	I.D. Registrar's Sign.	ature									
Vaga L	Registr		i'	MAYI	6 2006	Registrar's Sign	A.K.	1300 E	0							

			1 - For State Registrar	State of Marylar	-	ent of Health and ate of Death	Mental Hygien	Z U U D	15334
	Physici /Medic		1. Decedent's Name (First, Middle, Last) HAR	RY P.	Cock	RELL	MAY O	ay Yeer 4 2006	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give st. SAINT AGNES HOS			ity, Town, or Location of Dea	ith 4	c. County of Death	
	Funeral Director	7,7	5. Social Security Number 6. Sex 118	SPITAL 7. Age (In yrs. 7. Age (In yrs.		der 1 Year If Under 24 Hr		9. Birth	place (State or Foreign
	death with the Maryland me 23a or 28a-f ehow rmat be notified at	ector	Usual Residence of Decedent 10a. State 10b. County MD. BALT	10c. Ci	ty, Town or Location	-)/			1 ☐ Yes 2 ☑ No
	ath with the 23e or 2	Funeral Director	10e. Street and Number 1713 S. Ro	LLING	RD.	Zip Code 21227		Citizen of What Cou	7 .
980	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heelth and Mental Hygiene. Item 27 is marked other then "naturel; or iteme 23s or 28s-f show other traumatic event, in Medical Examinar mant be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Ament Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 12 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	e filed within 72 h at Hygiene. other then "netu vent, ine Medica	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		life. DO NO	work done during most of wi	orking	Kind of Business/In	
Maryland 2	should be filed and Mental Hygo marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last)	OCKREL	1	18. Mother's Na	ame (First, Middle, Maide	EVI	
	i and 2 sho leelth and m 27 le m		19a. Informant's Name/Rel Conship (Type Constitution)	BACH	36 +9 Place of Disposition (I	ess (Street and Number or F	ZINA AVE	EALTO.	MD. 234
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	BAV VIEU	or other place) M.	1 2005 13	ALTE.	WID:
Ball	permit. Pag Department important: I any injury o		21. Signature of general Service Licensee	Akarda	-h 28	and Address of Facility AP HUDSON	ST SH	ARDA	J-,H.
1	Pnysician /Medical	3 7	23a. Part1. Enter the disease, of complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the deal cause on each line. CLOSTRIDIN Due to (or as a consequence)	um DIFFIC	LE COUNTS	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ACUTE ON	CMRONIC	RENAL FAILU	RE		5 DAYS
8760,	certificate be executed nding physicien and use as the burial-transit	al Examine	Cause (Disease or injury that initiated events resulting in death) Last	HYPOTENSI Due to (or as a conseq	0N 5 ECON quence of):	DAKY TO SEPS	1'S		2 DAYS
P.O. Box 68	death certif ie attending ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	al death 3 Ectopic	: pregnancy (specify)		23d. Date of delive Month	ary Day Year
	S 5 0	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the underlyin	g cause given in Part I.		use contribute to the	ne cause of death?
of Vital Records,	The law ate has b page 2 s	Completed					24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:			eath (Check only one)		
of	<u>\$</u> ≥ 5	5	1 ☐ Yes 2 🗷 No	1 ☑ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of		Home 5 Residence		y)
Division	ing After une	Certification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) 28e. Place of Injury - At h	Injury M	28c. Injury at Work? 1 Yes 2 No	28f. Location (Street a		J. Davida Membar
Ω	spital or Attend nours after death neral Director: , filled in by the f		4 Homicide determined 29a. Certifier 154 Certifying Physic	building, etc. (Specia	(y)		City or Town, Sta	te)	
	ne Hospitai 24 hours a ne Funerai I	edicai		er: On the basis of examina and manner stated.	ation and/or investigat	ed at the time, date and plac- ion, in my opinion, death occ	e, and due to the cause(curred at the time, date a	s) and manner as s nd place, and due to	the cause(s)
)	within 2 To the	Me	29b. Signature and title of certifier	M.D		P 20347		ate signed (Month,	
1	1		30. Name and address of person who con	4					
1	- 01	to	RANUL JAIN 900 31. Date filed (Month, Day, Year) 2000	CATON AVEN	A a	IMORE MD 2	1229		
	Sta Registr		31. Date filed (Month Pay Year) 2006	alacus II	A STATE OF THE STA				

DHMH 17 Rev 1/2001

COCKRELL, MARRY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** OWN E. Mac 0630 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES

5. Social Security Number BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 459-15-0655 Usual Residence of Decedent 186 M 2□ F Yrs. Director with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d Inside City Limits 1 TYes 2 TWO Funeral Director OWSON 10e. Street end Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 0 d Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced HITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INTENANCE TECHNICIAN 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be DROTHY CARTER ပ္ ENTINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NTINE, BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place), 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5-12-06 HANOVER, M.D. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility ce Licensee Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena MD. 21122
Do not enter the mode of dying, such as cardiac or respiratory arrest, ter the disease, of complications that caused the de heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cancer. Immediate Cause (Final disease or condition resulting in death) Metastatic /Medical unknown Examiner Physician/Medical Examiner Encephalo Unllnows To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? ypertension 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No ineral Director: A filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Masood

State Registrar

31. Date filed (Month, Day, Year)

Khavrunnisa

32. Registrar's Signature

House &

M.D.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print).

Khairunnisa Masood, 900 Caton Avenue Baltimore, MD 21229

1)0062950

ALENTINE

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 3:12 DORIS E. CUMBERLAND MAY 2006 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GOOD SAMARITAN HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F 219-07-1304 4/3/1918 Director MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medicul Evantiner must be notified at 1 Yes 2 No Directo MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2819 LOUISE AVENUE 21214 USA Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Slatus e filed within 72 hours after al Hygiene." natural, or Ite 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRAPERY MANUFACTURING 11TH GRADE SEAMSTRESS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit thent of Health and Mental H tant: if Item 27 is marked oil ESTELLE ULLRICH RUDOLPH HEIGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN A. BARAN/DAUGHTER 5305 PEMBROKE AVENUE BALTIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) LAKE VIEW MEM. PARK 5/13/2006 SYKESVILLE, MD 21. Signature of Funeral Service Licensee ** Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final disease or condition resulting in death) Priysician Dilatolu /Medical Due to (or as a consequence of Examiner Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Felal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Mo 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 200 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number # AT -29b. Signalure and title of certifier 29d. Date signed (Month, Day, Year) 2438934 803 DSALIM BAGHLI MD Salin Knyhlig 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -GOOD SAMARITAN HOSPITAL BALTIMOLE-MD-21239 BAGHLI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 6 2006

UMBERLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#32, per DVR, 9855, 5/16/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 345 Kenneth Vernon Cullum, Sr. au /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square HOSPIta osedale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10XM 2□ F Days 219-36-0847 66 Director 1939 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Item 27 is marked other than "natural", or items 23s or 28s-4 show other traumatic event, the Michigal Examinar must be notified at Baltimore White Marsh 1 ☐ Yes 2 ☐ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21162 USA 6001 Lorelev Beach Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heavy Equipment Elementary/Secondary (0-12) College (1-4or 5+) Painter Manufacturer 11 18. Mother's Name (First, Middle, Maiden Sumame)
Helen Theresa Lindsey 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Cullum William Leo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m eny injury or other traum once. 6001 Loreley Beach Road, White Marsh, Maryland 21162 Laura Cullum - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 反 Burial 2 □ Cremation 3 □ Removal from State Air Mem. Gardens 05/17/2006 Fel Air, Maryland 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses Kussell 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Polmonary Immediate Cause (Final F. brosic **Physician** Y cans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine ettending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death signed by the eld be detached for 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy 2 No 2 No Division of Vital 1 Yes 1 TYes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending within 24 hours after death. To the Funerel Director; A 1 Yes 2 No investigation 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 241614 uu) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920 Halle Courshell 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 1 2 2006 May Paul Wesley Clarke 8:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carriage Hill Nursing Home Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
Aug. 30, 1912 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 577-22-1740 93 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir then "natural", or items 23a or 28a-t ehow the Madical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 9304 West Parkhill Drive 20814 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Examiner Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be til tment of Heelth and Mental H tent: It Item 27 Is marked otf Be Lee Martin Clarke Marian Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9304 West Parkhill Drive, Bethesda, Maryland 20814 Gary L. Clarke 20b. Place of Disposition (Name of cometery, crematory or other place)
Parklawn
Memorial Park Date 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗍 Cremation 3 🔲 Removal from State permit. Page Department of Important: It eny Injury or once. May 17, 2006 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Se Mostra M01420 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician Cancer of Pancreas /Medical Due to (or as a consequence of): Examiner Obstructive Jaundice Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transi Coronary Heart Disease that initiated events resulting in death) Last Due to (or as a consequence of): physicien s the burial Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) o. 9 Unknown 9 Unknown ت Part II. Other significent conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? (es 2 \(\) No 1 ☐ Yes of Vital Attending Physicien: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No this s atter death.

I Director: Atter this id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide To the Hospitel or within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) womas JOSUNIA D0047330 May 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Joseph, M.D. 50 W. Edmonston Drive, #207, Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

6 2006

			For State Registrar	State of Ma			of Health and of Death	Mental Hy	giene	15220
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of De Month	path Day Y	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give	Jean Bader street and number) ce Potomac	r Cooney	4b. City, To	wn, or Location of Dea	ath	14, 2006 4c. County of	
	Funeral Director		Social Security Number 6. Se		(In yrs. last birthda 88 Yrs.	Months [s. 8. Date of Bir	th ay, Year)	B. Birthplace (State or Foreign Country) Pennsylvania
	the Maryland 28a-f show	Director	10a. State 10b. County	omery	10c. City, Town or I	ocation	Chevy Cha	se	10g. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 ☒ No at Country?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygjene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examinat man be notified at	by Funerai	8100 Connectio	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☑ Note of Yes, Give Year or Dates:	ver in U.S. 13	. Was Deceder If Yes, specify	20815 t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Unit 14. Race- Black, Specify:	ed States American Indian, White, etc. White
Maryland 21215-0036	filed within 72 h Hygiene. other than "natuent, the weeks	Completed	15. Decedent's Edit (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	ucation le completed) College (1-4or 5+	(Giv	DO NOT use	doné during most of we etired) cretary			anking
arylanc	2 should be filed vand Mental Hygie is marked other transmitters.	To Be		pert J. Bac		ling Address (S	treet and Number or F	Edi	, Maiden Sumame) th Walton er, City or Town, St	
Baltimore, M	permit. Pages 1 and 2 Department of Heelth a Important: if item 27 is Any injury or other tra ance.		Paul E. Cooney/ 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Is 4 □ Donation 5 □ Other (Specify, 21. Signature of Funaraf Service Licens	Removal from State	20b. Place of Disp cemetery, cri Montgo Cremat	osition (Name ematory or othe mery orium I	nc. May	Date 15, 2006	20c. Location - Ci	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of fmmediate Cause (Final disease or condition	lications that caused the cause on each line	MOO335 Behe death. Do not e	<u>ethesda</u>	<u>, Maryland</u>	20814-3	501	Approximate Interval Between Onset and Death
8760, P	Medical deeth certificate be executed by Medical deeth direction and deform the burial transit deeth d	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Corona Due to (or as a	consequence of): ry Artery consequence of): cansequence of):	Diseas	e			
.O. Box 6	that the death certifica led by the ettending ph detached for use as ti	by Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pregi □ Other (speci			23d. Date of Month	
ords, P.	w requires that the been signed by th should be detache		Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying caus	e given in Part I.			ute to the cause of death? □ Probably 4 ⊠Unknown
al Reco	The law ste has b page 2 st	Completed							osy prio irmed? dea	re autopsy findings available or to completion of cause of th? Yes 2 No
Division of Vital Record	Attending Physician: r death. ector: After this certifice by the funeral director.	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	t 2 ER/Outpatie Year) 28b. Time Injury		Out		dence 6 Other	
Divis	tal or Atters after dea al Director ed in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, o	fice	28f. Location (S City or Tou	Street and Number (vn, State)	or Rural Route Number,
	To the Hospital or Attending Ph within Exh hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 1	sician: To the best of ner: On the basis of e and manner state	xamination and/or i	nvestigation, in	he time, date and plac my opinion, death occ cense number	surred at the time,	date and place, and	d due to the cause(s)
			· Jul	Shr	J		5128		29d. Date signed (# May 1.	5, 2006
	Sta	to	30. Name and address of person who con Anushiravan Dadgar 31. Date filed (Month, Day, Year)	, M.D. 971	5 Medical	Center	Drive #21	0 Rockvi	lle, Mary	yland 20850
	Registr	-	MAY 1 6 20	06 Alexander	's Signature	conte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#2,per/ID, (855,5/22/06 TT
State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registre Certificate of Death Reg. No. 2. Date of Death Month 12 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** May $\frac{5}{7}$, 2006 10:35 am Phillip /Medical John DiAngelo, Jr. 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore County Stella Maris Hospice | House | Hours | Min. | Substitution | Hours | Min. | Hours | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) 1**X** M 2□ F Yrs. Director 68 Maryland <u>219-32-4135</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐X√o Towson Maryland Baltimore Direct 10f. Zio Code 10g, Citizen of What Country? 10e Street and Number or Iteme 23a 20 Dunvale Road 21286 U. S. A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7: h and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Baltimore City Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Schiavo Phillip John DiAngelo, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s' of Health ar 6308 Meadow Drive Hurlock, Maryland 21643 <u>Maria Bona (Sister)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it any Injury or o 1 XBurial 2 Cremation 3 Removal from State 5/16 2006 4 Donation 5 Other (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service Reensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Home ohm Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Physician END STAGE CARDIOMUOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transif that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2**X** No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident

Box 68760 0. Records, Vital ŏ

DIANGELO

The law requires that the death certificate be executed signed by certificate after death.

Director: After this certific
I in by the funeral director. or Attending Division pellil. Hospitel within 24 hours a
To the Funeral (
completely filled

Maryland

10:35 а.ш.

Maryland 21215-0036

Baltimore,

Pages 1

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"natural"

Certification; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 721 1-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

State Registrar 32 Registrar's Signature

106

			For State Registrar	State of Marylan		rtment tificate					Reg. No	ZHHb	15341
	Physici	an	1. Decedent's Name (First, Middle, Last) Doris S. I	DeRuggiero					į	2. Date of De Month May		y 200 ^{Year}	3. Time of Death 12:02рм
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, T	own, or	Location of	f Death			. County of Deat	
		80.	350 Oberle Ave.		(a a de friende da col	Esse		If Under 2	04 Hrs	O Data of Riv		altimo	
N 100	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (In yrs. 79	Yrs.		Days	Hours	Min.	June 1	8 , 1	926 MAr	nplace (State or Foreign unit) y1and
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Maryli -f sho	tor	MD Baltimo	ore	E	ssex							1 ☐ Yes 2 X No
	h with the	Funeral Director	10e. Street and Number 350 Oberle Ave.	•		10f. Zip 0	Code 221				10g. Ci	tizen of What Co	untry?
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. If item 27 is marked other then "neturel", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be multified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decede Yes, specif			in? (Spec Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	e, etc.
215-0	within 72 ho ene. then 'netu ne Madical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	lent's Usual kind of work DO NOT use memal	done d retired)	tion uring most	of workin	g		ind of Business/	Industry
Maryland 21215-0036	ild be filed w lental Hygiei ked other ti ic event, In	To Be Col	12th 17. Father's Name (First, Middle, Last) George Walton							(First, Middle Clar	, Maider		
Mary	alth and Men 27 le marke traumatic		19a. Informant's Name/Relationship (Type Michele D. The									or Town, State, 2 MD 212	
Baltimore,	Pages 1 and of Heilen int: If item		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Charles Charles C	lace of Dispo- emetery, crem YV1CW	natory or oth	ner place	ory	4	6/06		ocation - City or timore	
Balti	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service License	onnelle		. Name and			300			e. Bal Essex	
· · · · · · · · · · · · · · · · · · ·	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	COLON	C A		of dying						Approximate Interval Between Onset and Death
8760,	Examiner hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq D)	uence of): TEF uence of):		N	ー		ea e			
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	luires that signed b lid be deta	ρ	Part II. Other significant conditions cont	ributing to death but not res		nderlying ca	use give	n in Part I.		23e. Did 1		_	the cause of death?
Il Records,	The ste h	Completed	0) TEO (6 Rus1>						24a. Was auto perfo 1 \(\text{Yes} \)	psy ormed?_	prior to death?	topsy findings available completion of cause of
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes No	ospital:	ER/Outpatien	t 3 🗆 DOA	Othe	r		Check only		s 🗆 🗆 (C.)	- 4.V
Division of Vital	After Lune	Η,	1 Yes No 27. Manner of Death Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury Work	4 🔲 Nui		8d. Describe		6 ☐Other (Spec ry occurred	city)
Divisi	를 를 들	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory,	affice		2	8f. Location (City or To			ıral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physical Examination	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a restigation,	t the tim	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s date an) and manner as d place, and due	stated, to the cause(s)
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6	0		30 Name and address of person who cor	OFRN'S M	2	22C	4	Clo	SAC	~ A	ري	BALTO	2006 , MD2123]
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			For State	State of Maryland				d Mental Hy	giene	
			Registrar		Cer	tificate o	Death		Reg. No. 2 0 0	15342
i	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Elizabeth	Duschl				2. Date of De Month May	Day Year 11 200	3. Time of Death 7:53a _M
9	Examin		4a. Facility Name (If not institution, give s				or Location of De		4c. County of Dea Baltim	ore
			Ivy Hall Nursi 5. Social Security Number 6. Sex		t hirthdout	M1 CC	lle Rive			thplace (State or Foreign
	Funeral Director			м 25xF 79	Yrs.	Months Day		lin. Dec.	22,1926 MA	ryland
	2		Usual Residence of Decedent	10- Ci- 1						10d. Inside City Limits
	arylar ehow	_	10a. State 10b. County MD Baltimo	ore Ess	own or Lo	cation				1 Tyes 2 Mo
	Ba-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	n 72 hours after death with the Maryland "neturel", or Itema 23a or 28a-f ehow salcal Esamirer must be notified at	급	286 Montrose Av	re.		2122			USA	Suriu y :
	ne 23	Funeral		2. Was Decedent Ever in U.S.	13. \	Was Decedent o	Hispanic Origin?	(Specify Yes or No	0- 14. Race - Am	
9	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		t Yes, specnry Ct 1 □ Yes 2 ②cN	uban, Mexican, Pu o <i>Specify:</i>	ierto Hican, etc.)	Black, Whi	hite
8	ref.	d by	3X Widowed 4 □ Divorced	Year or Dates:						
က်	"netu	ete	15. Decedent's Educ (Specify only highest grade		(Give	tent's Usual Occ kind of work dor DO NOT use reti	e during most of	working	16b. Kind of Business L.Grief	
12	withis ene.	Completed	Elementary/Secondary (0-12) 6th	College (1-4or 5+)	Fac	ctory V	lorker-	Clothing	J.Gilei	a co.
2	be filed within 72 hours after ital Hygiene. Id other then "neturel", or ite event, the Medical Examina	Be C	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
<u>la</u>		ToB	William Shrive	er			Lil	lian Baı	cr	
Maryland 21215-003	2 4 2 2		19a. Informant's Name/Relationship (Type						ner, City or Town, State,	
		17	Joann Evans / C	20b. Plac	e of Dispo	sition (Name of	Ţ	Date	20c. Location - City or	
altimore,	permit. Pages 1 en Department of Heel Importent: If Item 2 eny Injury or other once.		1 ☐ Burial 2X☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	cerr	netery, cren	natory`or other p Cremat	ory 5	115/06	Baltimore	
Ħ	permit. P Departme importen eny injur		21. Signature of Funeral Service License	ne /)) 22	. Name and Add			Ave. Bal	to. MD
m	Ped in a		P. Terry	Connell	40	Connell	y Funei	ral Home	of Essex	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only or	cations that caused the death	not ent	er the mode of d	ying, such as card	diac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	broken	re	Dech	m			Criser and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	1	Dise		1=1-1	- ha C	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a donseque	nce of):	DVAC	are our	ins fall	- palian y	27
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õ	requi	eted	Topia van	- was	1001	* * /// ().	7 - (0) 10	1		
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ā	in: Ti ificete or, pa	ပိ	25. Was case referred to medical				as Place of I	1 ☐ Yes Death (Check only		s 2 No
5	ysicia s cert direct	ToB	evaminer?	ospital: 1 ☐ Inpatient 2 ☐ EF	NOutpatien	nt 3 DOA			idence 6 □Other (Spe	ecify)
2	ng Ph ter thi neral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of	28c. In	jury at	28d. Describe	how injury occurred	
Sion	Attendin death. ctor: Af y the fur	catlo	2 Accident investigation				□Yes 2□No			
Division of Vital Records,	for Att efter de Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, offic	e		(Street and Number or F own, State)	ural Route Number,
∴	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phys	sician: To the best of my knowle	edge, death	n occurred at the	time, date and nl	ace, and due to the	cause(s) and manner a	s stated.
	1 24 h	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examinatio and manner stated.	n and/or in	vestigation, in m	y opinion, death o	ccurred at the time,	, date and place, and du	e to the cause(s)
	To th To th comp	ž	29b. Signature and title of certifier	2		29c. Lice	ense number		29d. Date signed (Mon	
	5		farth.	N V	h 1)		21441	4	2/12/0	6
1	4 '		30. Name and address of person who co		(Type,	Print)	T C H	3 % C	RALTIMA	Lt MD 2120
	Sta	ite	STOAIS A - ITAS. 31. Date filed (Month, Day, Year)	32. Registrar's Signatu		11600	1 amu	() ()	1317 - (11/(0)	111/ 2120
	Regist		SERV 1 C 21	- B	e de					

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of He	ealth and Mental Hygieneo

	For State Registrar		ertificate of Death	Reg.	No.	1007		
Physician	Decedent's Name (First, Middle, Last) Dacia Devona Dunso			2. Date of Death Month May 12,	Day Year 2006	3. Time of Death 9:30 PM N		
/Medical Examiner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	·	4c. County of Deat	h		
	301 Warren Avenue	#415	Baltimore		Baltimore	e City		
Funeral Director	422-02-0695	7. Age (In yrs. last birthda M 25 33 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo 05/04/19	9. Birtl Co 273 AL	hplace (State or Foreig untry)		
death with the Maryland ma 23e or 28e-1 show rmust be notified at neveral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limit		
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with the sor 2 Direct	10e. Street and Number 301 Warren Avenue,	#415	10f. Zip Code 21230		. Citizen of What Co nited Stat			
urs after death very of tema 23e	11. Marital Status 1 Never Married 2 Married		3. Was Decedent of Hispanic Origin? (Single of Yes, specify Cuban, Mexican, Puerton of The Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In minoriant: If term 27 is marked other than "naturel; or itema 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at once. To Be Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade	cation 16a. De (G. (G. (G. (G. (G. (G. (G. (G. (G. (G.	cedent's Usual Occupation ive kind of work done during most of wor b. DO NOT use retired) Y Editor	king Ba	Sb. Kind of Business/Industry altimore Sun Paper			
Mental Hygarked otheratic event,	17. Father's Name (First, Middle, Last) LeVanure Zimmerma:	n	18. Mother's Nan Sharon	ne (First, Middle, Mai Dunson	iden Surname)			
d 2 shoul th and M 7 is mark traumati	19a. Informant's Name/Relationship (Ty Mr. Michael Workman		ailing Address (Street and Number or Ru Warren Avenue, #4					
Definition of your population of Healing Department of Healing Department: If Item 2 any injury or other pace.	20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Place of Discemetery, of	sposition (Name of	Date 200 May 15	c. Location - City or a	Town, State		
permit. P Departme Importan any injur	21. Signature of Funeral Service Licens		2. Name and Address of Facility Cremation and Funeral Alternatives B717 Green Pastures Drive Baltimore, Maryland					
Licate be executed physician and physician and street be unial-transit the burial-transit edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				5/200		
To the Hospital or Attending Physicien: The law requires that the deeth certificate be execu within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra Medical Certification: To Be Completed by Physician/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	very Day Year		
uires that n signed b	Part II. Other significant conditions con	ntributing to death but not resulting in the	a underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	cco use contribute to	the cause of death?		
lor Attending Physicien: The law requires the after death. Director: Atten this certificate has been signed in by the funeral director, page 2 should be a ertification: To Be Completed by				24a. Was an autopsy performed	d? death?	topsy findings availa completion of cause of		
hysician his certifi il director	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3□ DOA Other: 4□ Nursing H	th <i>(Check only one)</i> ome 5 Residenc		cify)		
tal or Attending P is after death. al Director: After the ed in by the funera Certification:	27. Manner of Jeath 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury 28b. Time (Month, Day Year) Injur	y Work? M 1 □ Yes 2 □ No	28d. Describe how				
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S				
the Hosp thin 24 hou the Funei impletely fil	one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)		
To t Com	29b. Signature and title of certifier	~, M.I)	29c. License number 053070	29d.	Date signed (Month			
1	THE THE PERSON NAMED IN TH			B91+	/			

			1 - For State Registrar	State of Maryland / Depa Cer	irtment of Health and tificate of Death	Mental Hygier	44CCC 0007
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) Miya Alexis As Facility Name (If not institution, give si		4b. City, Town, or Location of Dea	March 2	Year 3. Time of Death 4 2006 11-30 MM
	Funeral Director		211 /3 2/01		Fort Washing	8. Date of Birth (Month, Day, Yea March 9,	PG 9. Birthplace (State or Foreign 2006 Mary Tand
	ne Maryland Be-f ahow Affied at	Director	Usual Residence of Decedent 10a. State 10b. County MD . PG	10c. City, Town or Loc Suitland			10d. Inside City Limits 1√2 Yes 2 □ No
15-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28e-f ahow any injury or other treumatic avent, I'm Medical Evanions missible Incilliad at ODGE.	Completed by Funeral Dire	Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	2. Was Decedent Ever in U.S. Armed Forces? 1	10f. Zip Code 20746 Vas Decedent of Hispanic Origin? (See Specify Cuban, Mexican, Puer Yes, Specify Cuban, Mexican, Puer Yes, Specify: ent's Usual Occupation wind of work done during most of work done Of NoT use retired)	Specify Yes or Noto Rican, etc.)	Citizen of What Country? A 14. Race - American Indian, Black, White, etc. Specify: BLACK Kind of Business/Industry
Maryland 21215-0036	ould be filed withi Mental Hygiene. Narked other than natic avent, the M	To Be Comp	Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last) MichaelDrayt	College (1-4or 5+)	18. Mother's Na	me (First, Middle, Maide E. Diggs	an Sumame) Drayton
altimore, Mar	Pages 1 and 2 sh ient of Health and nt: If Item 27 is m ry or other treum		19a. Informant's Name/Relationship (Typ Michael Drayton] 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	II (Father) 4405 20b. Place of Dispose commetery, crem	g Address (Street and Number or R Covington St. sition (Name of reatory or other place) Cemetery Mar	Suitland, Date 20c.	MD 20746 Location - City or Town, State
Balti	permit. Departm Importe any inju	0 00	21. Signatur if Funeral Service License	е 22.	Name and Address of Facility Tr 732 Georgia Av	ri-State E ve.NW., Wa	r/s 20011
8760, 0	The law requires that the death certificate be executed X X I was been signed by the attending physicien and in a piper or age 2 should be detached for use as the burial-transit	dical Examiner	shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Kidney Failure/Re Due to (or as a consequence of): Multiple Congenit Due to (or as a consequence of): Due to (or as a consequence of):	nal Agenesis		Interval Batween Onset and Death
.O. Box 6	that the death certificated by the attending placed by the attending placed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P	n requires that been signed b should be deta	þ	Part II. Other significant conditions cont	tributing to death but not resulting in the un	derlying cause given in Part I.	1 🗆 Yes	o use contribute to the cause of death?
Vital Records,		Be Completed	25. Was case referred to medical examiner?			24a. Was an autopsy performed? 1 Yes 2 X Nath (Check only one)	
Division of V	ding Phy h. After this funeral c	Certification: To E	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Inpatient 2 I ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	
DIX	To tha Hospital or Attenwithin 24 hours after deat To the Funerel Director:		4 Homicide determined 29a. Certifier 1 Certifying Physi	28e. Place of Injury - At home, farm, stre building, etc. (Specify) ician: To the best of my knowledge, death	occurred at the time, date and place	City or Town, Sta	s) and manner as stated.
	To the Ho within 24. To the Fu completel	Medical	(Check only 2 Medicel Exeminone) 29b. Signature and title of certifier	er: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death occi	29d. D	nd place, and due to the cause(s) Pate signed (Month, Day, Year) 11 4, 2006
	2		Angela Joy F	npleted cause of death (Item 23a) (Type, F	Print) Winton, 1		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2006	32 Hegistrar's Signature	with the same of t		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#29d,permD,C855,5/15/06 TT
State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Robert 1:50 May 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital ROCKVILLE Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 078-30.4938 Yrs. 68 Director December 10,1937 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Rockville Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Street 213 Upton 20850 or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than .rry or other treumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) Entertainment Industry Caterer 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence Hertel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 213 MD Upton Street Rockuille Joanne Dal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, Anatomy Gifts Registry May 9, 2006 permit. Pag Department Important: any injury o 4. Conation 5 ☐ Other (Specify) 22. Name and Address of acility Anatomy Gifts Registry 21. Signature of Fundral Service Licenses 1522 Connelley Drive Suite P. Honover 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Cardiac Arrest resulting in death) /Medical Due to (or as a consequence of): Examiner Afibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 🗷 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation the f 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptifier 29300 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L Gold M.D. 15225 Shedy Grove Road . Suite 201 , Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 5 State 2006 Registrar

		For State Registrar		laryland						Reg. No.	06	15346
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James Hanry EASLEY
Baltimore, Maryland 21215-0036

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State of Maryland / Department of Health and Mental Hygien [] []

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	Physici	i an	Decedent's Name (First,	Middle, Last,)					2. Date of I	Death Da	ay	Year	3. Time o	of Death
	/Medic		James H.							Mai	1 6	, 3	006	5:4	54M
1	Examir	ner	4a. Facility Name (If not ins	_				4b. City, Town, o		ath 2		c. County			
	Funeral		Doctors Co 5. Social Security Number	6. Se		a⊥ ge (In yrs. last b	irthday)	Lanhan If Under 1 Year	If Under 24 H			ince		rges lace (State stry)	or Foreign
÷.	Director		223-09-3086 Usual Residence of Deced		3 M 2□F	91	Yrs.	Months Days	Hours Mi		01 14			ond,	
	yland		10a. State 10b. 0	County		10c. City, Tov	wn or Loc	ation					1	0d. Inside C	City Limits
)	ith the Marylar or 28a-1 show	ctor	MD Pri	nce Ge	orges	Glend	dale							1X Yes	s 2□No
	filed within 72 hours after death with the Maryland Hygiene other than "natural", or iteme 23a or 28a-f show ent, the Macical Examinat must be notified at	by Funeral Director	10e. Street and Number					10f. Zip Code			10g. C	itizen of W	/hat Cour	itry?	
	e 23e	rai	12406 Rans			- F :- 11 O	140.111	20769				USA			
	ter de	-un	11. Marital Status 1 ☐ Never Married 2[Married	12. Was Deceden Armed Forces 1 X Yes 2	? ? ! No	IS. VV	as Decedent of H Yes, specify Cuba	an, Mexican, Pue	orto Rican, etc.)	NO-		k, White,	an Indian, etc.	
21215-0036	urs af		3 ₩ Widowed 4 Div		ff Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify:			Specify.	B1a	.ck	
5-0	natur	Completed	15. De (Specify only	cedent's Edu	cation e completed)	168	Decede	nt's Usual Occup	ation	orkina	16b. h	Kind of Bu	siness/Ind	dustry	
121	han.	пр	Elementary/Secondary (Colfege (1-4or	5+)		ind of work done of NOT use retired	d)	og					
12	Hygien Hygien Ther ti		12 17. Father's Name (First, M	liddle (ast)			Co	ook	19 Mother's N	ame (First, Mido				h's H	osp.
rland	Aental }	To Be	James Easle							ice Gibb		Joinain	9)		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hyglene. Item 27 is marked other than "natural", or iteme 23e or 28e-1 show other traumatic svent, It's Mudical Examinar must be notified at		19a. Informant's Name/Re Barbara					Address (Street 6 Ranson						Code)	
Baltimore,	e = = 5		20a. Method of Disposition 1 XBuriaf 2 Crem 4 Donation 5 0			cemete	ery, crema	tion (Name of atory or other plac National		Date 5-06		rel,		wn, State	
altii	permit. Pa Departmer Important: any Injury		21. Signature of Funeral S			Haryr		Name and Addres		Marshall				me	
8	Depa Impo any is	1,77	P	Ma	rshal	10	42	217 9th.							
9			23a. Part / nter e disea sh ck or h rt failure	ise, or compl b. List only or	ications that cause ne cause on each	d the death. Do								Approxima Interval Be	tween
	Physician		Immediale Cause (Final disease or condition resulting in death)	6	Met	as tate	ei	Rept	ate (ance.			- 4	Onset and	Death
	/Medical Examiner		resulting in death)		Due to lor a:	s a consequence	of):	. A. at	2116						
	A. 5-85.	-	Sequentiafly fist conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	, l	Due to (or as	s a consequence	of):	ing,	cus				-		
/	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	Hyl	crkal	eme	4							
6	en an en an rrial-tr		resulting in death) Last		Due (ra:	s a consequence	of):								
68760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Medicai			d										
	ertificate ling physise as the		IF FEMALE:		00-16										
Вох	eath cer attendir for use	Physician/	23b. Was decedent pregna in the past 12 months	li i l		e of pregnancy 2 ☐ Fetal death at time of death		ctopic pregnancy				23d. Date Mon		-	Year
o.	at the de by the stached	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unknown	it time or death	5 🗆 (Other (specify)						,	
Δ.	res that igned by be deta	by Ph	Part II. Other significant co	nditions cor	ntributing to death	but not resulting	in the unc	derlying cause give	en in Part I.	23e. Dio	tobacco	use contri	bute to th	e cause of	death?
of Vital Records,	w requires been sig should be									1	Yes 2	□No	3 🗌 Prob	ably 40	Unknown
၀	aw re	Completed								24a. Wa		24b. W	ere autor	osy findings	available
Ä	The lavate has	Eo									opsy formed? 2 No	de	fior to con eath? □ Yes	npletion of a	cause of
/ita	sicien: Th certificate irector, pag	Be C	25. Was case referred to mexaminer?	edical					26. Pface of De	eath (Check only					
) (Physicien: this certifica	၉	1 ☐ Yes 2 🗹 No	-	lospital: 1 Inpat			3 DOA Othe	4 Nursing	Home 5 ☐ Re	sidence	6 □Othe	r (Specify)	•
	ding F h. After funera	ion:		ending	28a. Date of Inj (Month, D	ay Year) 28b.	Time of Injury	28c. injun Work		28d. Describe	how inju	ry occurre	d		
Division	l or Attending after death. Director: After in by the funer	ficat	3 Suicide 6	ould not be	28e. Place of fr	ijury - At home, f	arm stree		Yes 2 No	28f. Location	(Street at	nd Numbe	r or Rura	I Route Num	nhar
Ο̈́	i tte	Certification:	4 Homicide	letermined	building, e	tc. (Specify)		n, ractory, circo		City or T	own, State	a)		77031077411	1007,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 Cs (Check only 2 Me	rtifying Phys dicel Exami	sician: To the best ner: On the basis of and manner s	of examination at	je, death o nd/or inve	occurred at the timestigation, in my op-	ne, date and place pinion, death occ	e, and due to the	e cause(s e, date an) and mar d place, a	ner as stand due to	ated. the cause(s	s)
	To the To the comp	ž	29b. Signature and title of	ertifier	21.	1	/	29c. License			29d. Da	te signed	(Month, L	Day, Year)	
)	1		1 Am	1 /	the 1	the ca	n. P	D5	9993		05	105	10	6	
	5		30. Name and address of p	erson who co	ompleted cause of	death (Item 23a)	(Type, P	rint)	1 a 1a	M 1	2				
100	Sta	te	31. Date filed (Month, Day,	Year)	32. Regist	8 Goed L rats Signature	ucis	Road L	unvam	ria	2070	26			
	Sta	ite	31. Date med (Month, Day,	rear)	JZ. Hegist	rans Signature	190	A STATE OF THE STA							

		•	For State Registrar		State o	of Maryla	ind / Depa		of Healt of Dea		ental Hy	gienę Reg. No.	ZIIIIb	15349
	Physici		1. Decedent's Name (Fig. MARIA ES	irst, Middle, Las SPINAL	t)						2. Date of De Month MAY 5,		Year	3. Time of Death 1:20 PM
	/Medic Examin		4a. Facility Name (If not CASEY HOUSE 5. Social Security Numb	er 6. So			rs. last birthday) Yrs.	ROC If Under	Fown, or Location CKVILLE 1 Year If Unit Days Hou	der 24 Hrs.	8. Date of Bil (Month, Da	4c. MC	Cour	
	Director			b. County			City, Town or Lo				MAY 13	, 1953		LVADOR 10d. Inside City Limits
	death with the Maryland	Director	MARYLAND 1 10e. Street and Number 13209 DAIRYM			n	GERMANT	OWN 10f. Zip	Code 20874			10g. Citi	zen of What Cour	1 ☐ Yes 2X No ntry?
20	s after death or Items 23	by Funeral	11. Marital Status	2[X Married	12. Was Dec Armed Fo 1Yes If Yes, Gi	edent Ever in orces? 2 X No ve		Was Deced If Yes, spec	ent of Hispanic fly Cuban, Mex		ecify Yes or No Rican, etc.)		14. Race - Americ Black, White,	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelith and Mental Hygiene. The file file is 28 or 28s-f show file m21 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exaction matter notified at	Completed b	3 Widowed 4 15. (Specify of Elementary/Secondar	Decedent's Econly highest gra	Year or Ducation de completed) College ((Give	dent's Usua kind of word DO NOT us	l Occupation k done during r e retired)				nd of Business/in	
yiand 21	uld be filed with fentat Hygiene. rked other ther itc event, the h	To Be Cor	17. Father's Name (First	t, Middle, Last) ESPINAL	3		ELEC	<u> </u>			(First, Middle	, Maiden	NSTRUCTION Surname)	N
, mar	end 2 should be eeith and Mental m 27 is marked on her traumatic ev		19a. Informant's Name/	SPINAL -			2987	SHADOWT	RAIL DRI	VE; HOUS	STON TX	77082	r Town, State, Zip	
IIImore	t. Page rtment o rtant: If njury or		20a. Method of Dispositi 1 Burial 2 Cr 4 Donation 5 C 21. Signature of Funera	remation 3 🗍 Other (Specify)	State	Place of Dispo cemetery, creations ORT LINCO	LN CREM		5/15/2		BREN	TWOOD, MD	
Dalt	Depar Depar Impo		> Myel	in T. U	Cobert		1	1800 NE	W HAMPSH	IRE AVE;	SILVER	SPRIN	UNERAL HON G MD 20904	
	cate be executed /Medical Examiner the burial-transit	dical Examiner	23a. Part1. Enter the di shock, or heart fai Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injurt that initiated events resulting in death) Last	ons, diate	a. COL Due to b. Due to	ON CANCE (or as a consi	ER equence of):		or of the					Approximate Interval Between Onset and Death
. Box o	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 □ No 9 ☒ Unknown	iths?		ointh 2 ☐ Fe nantattime of	etal death 3	Ectopic pre Other (spe				2	3d. Date of delive Month	ery Day Year
cords, P.	w requires that the de been signed by the should be detached	۵	Part II. Other significan	et conditions co	ontributing to d	eath but not re	esulting in the u	nderlying ca	use given in P	art I.				ne cause of death?
Ž Z	The lavele has	e Completed	25. Was case referred t	to modical							1□ Yes	psy ormed? 2☐XNo	24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 No
10 V	Physicien: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	to medical			☐ ER/Outpatier		A Other: 4		<i>(Check only o</i> ne 5□Resi		i ⊠Other (Specif	y) HOSPICE
		ertification:	2 Accident	Pending investigation Could not be determined	28e. Place	of Injury th, Day Year)	home, farm, str	М	3c. Injury at Work? 1 ☐ Yes 2	2 □ No	28d. Describe	Street and	d Number or Rura	d Route Number,
5	To the Hospital or Attending within 24 hours after death. Ye the Funeral Director: After completely filled in by the funeral Director.	Medical Cert	29a. Certifier 1X	Certifying Ph Madical Exam	ysician: To the	best of my kasis of examiner stated.	nowledge, deat	h occurred a	at the time, date in my opinion,	e and place, a death occurre	City or To	cause(s)	and manner as si place, and due to	tated. the cause(s)
h	To the within :	Mec	29b. Signature and title	of certifier	\smile	Wi	>		License numb	per			signed (Month, 5, 2006	Day, Year)
2	~ \ \		30. Name and address of JOSEPH KAPLAN				em 23a) (Type, LL ROAD;	,	LLE MD 20	0855				
,	Sta Registr		31. Date filed (Month, D	6 2006	32. F	Registrar's Sig	20	وع						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** May 15, 2006 Margaret Cecilia Everman 5:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days 1 ☐ M 2 🔽 F Hours Director 90 March 18, 1916 165-03-4542 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State is 1 and 2 should be filed within 72 hours after death with the Marylan if Heath and Mental Hyglene. The file is 7 is marked other then "neture!", or items 28a or 28a-1 show other transmitic event, the Medical Examinar multi-the notified at 10d. Inside City Limits 1 X Yes 2 ☐ No Director **Maryland** Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Russell Avenue #615 20877 Funeral **United States** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 🛱 No If Yes, Give Specify: þ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filt trent of Health and Mental Hy tant: if Item 27 is marked oth jury or other traumatic event Be ٥ Samuel Palmer Everman Margaret Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erich E. Baumgartner/Nephew 18 Old Creek Court Rockville, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. omery torium Inc. May 16, 2006 Bethesda, Maryland 22. Name and Address of Facility Kobert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M00335 23a. Part1. Enter the disease, a conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician electrolyte imbalance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner denent'a advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Funknown Hypothyroid Hyportension 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a To the Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rejcella Cellahar Lys 041794

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Spark

911 Russell Ave Gaithersburg mD 20879

ho completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

mp

Priscilla Callahan-Lyon,

6 2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Robert Joseph Ferris, Sr. Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Deat Physician/ Month Day May 13, 2006 1446 hrs Medical Examiner ROBERT JOSEPH FERRIS, SR. 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Min Hours 214-03-7867 Director 2/25/1916 MD 90 Country) 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location È 10a. State Yes 2 XNo 28a-f show MD BALTIMORE PARKVILLE or items 23a or 28a-f shormust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 8810 WALTHER BLVD. APT. 3403 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year WWII 1 Yes 2 X No specify. 3 X Widowed Specify WHITE 4 Divorced <u>۾</u> or Dates: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical ACCOUNTANT POMPEIAN OIL 2 YEARS and Mental Hygiene. 27 is marked other th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) MARTIN A. FERRIS Be AMELIA K. BURKHAUSER 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m traumatic 9 MARY SCHROEN/DAUGHTER 7919 HILLENDALE ROAD BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Department o Important: injury or oth 5/16/2006 CATONSVILLE, MD METRO CREMATORY, INC. Donation 5 Other Specify 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 ations trat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval rt I. Enter the disease, or comp Physician Between Onset and failure. List only one cause on Ach line. /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED physician the burial -Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery requires that the death certificate 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ 1 Yes 2 No 3 Probably 4 V Unknown ₫. Renal failure; cirrhosis pleted Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Comp Yes 2 ✓ Yes No this certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital æ examiner? Other₄ Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 1 🗸 Natural Division 1 Yes 2 No Pending death Director: the Certificati Accident Investigation 24 hours after d Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 14, 2006 ne and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Date filed (Month, Day, Year) State Registrar

	1	For State Registrar	State of Ma		artmer rtifica		ealth and Death		Re	g. No	006	1535
ysiciar		I. Decedent's Name (First, Middle, Las Oral Joseph Fishe							Date of Death Month 05	1Day	2006	3. Time of Death 8:50am
Nedica	1	a. Facility Name (If not institution, give			4b. City	. Town, or	Location of Dea		05		ounty of Dea	
amine		Casey House	Stroot and framesty		1	Rockv					Montgo	
eral	5	5. Social Security Number 6. Se		(In yrs. last birthday,	If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min		Date of Birth (Month, Day,			rthplace (State or Fore
ctor		332-24-0257	2 M 2 □ F	89 Yrs.	MOTILIS	Days	Hours Will		1-25-		Lo	ouisiana
220	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation.							10d. Inside City Lim
9 1	.	MD Montgon		Silver		nø						1 (XYes 2 🗀 I
Direct	בַּב	10e. Street and Number 3615 Leisure Worl		BIIVEI		ip Code	20906		10		n of What C	ountry?
any injury or other traumatic event, tra Medical Evans arrives be notified at 000ce. To Be Completed by Europei Director	Completed by Funeral Director	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1774 es 2 DNo If Yes, Give Year or Dates:	ver in U.S. 13.	Was Dece If Yes, spe 1 Yes		spanic Origin? (: n, Mexican, Pue Specify:	Specify rto Rica	Yes or No- in, etc.)		Race - Am Black, Wh	
1	Sec.	15. Decedent's Ed (Specify only highest grad		16a. Dece	edent's Usu	ual Occupa	ition Juring most of wo	nrkına	1	6b. Kind	of Busines	s/industry
100	- d	Elementary/Secondary (0-12)	College (1-4or 5+	-)			luring most of wo	, Kiriy		C		- 4-
100	5 -		4+	рет	ot of	реге					ernme	
9	0 _	17. Father's Name (First, Middle, Last) Marshall Fisher						arei	Knigl	nt F	isher	
		19a. Informant's Name/Relationship (7 Barbara H. Fisher	ype, Print) r/wife	19b. Mail 3615	ing Addres Leis	s (Street a	World S	ilval Ro	er Spri	City or I ing I	own, State, MD 209	Zip Code) 906
5	12	20a. Method of Disposition 1 ☐ Burial 25€ cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	matory or	other place		Date				r Town, State
o fun		4 Donation 5 Other (Specify)	Chesapea	ake C	remat	ory 05	-16-	-2006	Be:	ltsvi1	.1e, MD
any injury or other traumatic event, the Mis 2006e.		21. Signature of Funeral Service Licen	2 miss	× 2	Rap	p Fun	s of Facility eral & (Ave_Si	Cre	nation Sprin	Serv	7ice	0
ne burial-transit	Icai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Prosta Due to (or as a c.	Renal Fai consequence of): ate Cancer euroequence of):								
Macialand		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic p					230	d. Date of de Month	olivery Day Year
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oage 2 sh	E						26. Place of De	eath (C		S. 000		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:40PM Marie Wilmer Fischer MAY 13 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES BALTIMORE ST. HEALTMCARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 XF 216-16-6187 82 Director Aug.19, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland |Baltimore Directo Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 5420 Masefield Road 21229 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Life Ins. Secretary 12 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 4 pg + Mental f Health and Menta 0 Pages 1 and 2 should Lawrence M. Whiteside Lillian C. Merrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford Lawrence Wiskeman/Nephew 18 Fox Meadow Garth; Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition , E 1 XBurial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or Meadow Branch Cem. 5/17/2006 Westminster, Maryland 4 ☐ Donation, 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 ebec 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List in one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS DAYS Physician /Medical Due to (or as a consequence of): Examiner INFECTION INARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Вох IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown o 9 Unknown σ. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown MELLITUS Record Be Completed 24b. Were autopsy findings available prior to completion of cause of death? PERTENSION 24a. Was an page 2 certificate has autopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Vital or Attending Physician: After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 3□ DOA ð 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1@ Conflying Physiciam: To the best of my knowledge death occurred at the time, data and place and due to the cause(s) and manner as stated 29a. Certifier To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) <u>e</u> 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Meren P18619 MAY 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES MEANTH CARE, MD 2/220 JIBRIN MD S7. SMAJLA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bleen & Registrar

			State of Maryland / Department of Health and N State Registrar Certificate of Death		ene2006	5 15354
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio		WILLIE MAE FANT	May	10 2006	14:41p M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	ath
			HARFORD MEMORIAL HOSPITAL Havre de Grace	, , , , , , , , , , , , , , , , , , , ,	HARFOI	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 M 2 T P P P P P P P P P P P P P P P P P P	8. Date of Birth (Month, Day, FEB 19 1	9. B	irthplace (State or Foreign Country) EORGIA
	Director		252-34-0107 1 M 2A 81 Yrs. Usual Residence of Decedent	FEB 19 1	.925 GI	LORGIA
	and		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Manyl f sho	ō	MARYLAND HARFORD CO ABERDEEN			1 ☐ Yes 2X No
	the t	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What (Country?
	3a or		215 SPESUTIA RD 21001		U.S.A.	
	ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - An Black, Wi	nerican Indian,
	after or ite	Ē	1 Never Married 2 Married 1 Yes, Give 1 Yes 2 No Specify:	riioari, etc.)	Consifus	
	ours	d by	3 Widowed 4 Divorced Year or Dates:			BLACK
	21215-0036 od within 72 hours aff gione. or then "naturel", or the Madical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ting 1	6b. Kind of Busines	s/Industry
	vithin ne.	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		N/A	
	Iled v Hygie Hyert nt. III		12th grade HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M		
	and the final the of others:	Be	1/3 7/7/1	A WEBB	,	
	ryli hould d Me mark matic	70	WILLIE PARKS MARTHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur		City or Town. State	. Zip Code)
*	Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event	n,			23AA	
	Heal	11 8	20a Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City	
0	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other traumatic event. It is Marical Examinar must be notified at once.		1 △ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) ARLINGTON NATIONAL 05-20	6-06	RLINGTON	VIRGINIA
3	Iltin		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
	Bal permit Depar Impor		WM C BROWN COMMUNITY	TY FUNERA	L HOME-H	ARFORD, P.A.
			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death) a			مر و دوم
1	Examiner		Caro a disease			3 years
2)	The same of	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			9
SI	60, K	Examiner	that initiated events c			
3	60, 2 be executician and burial-train		resulting in death) Last Due to (or as a consequence of):			
	0 5 0	lical	d			
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0	Is, P.O. Box res that the death cer igned by the attendir be detached for use	an/	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of o	lelivery Day Year
	. 0 00 0	sici	1 Yes 2 No 9 Unknown 5 Other (specify)			
-	ords, P.O	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
3	ds, Puires that signed I	by	Hypertension	1 □ Ye	s 28∂No 3□	Probably 4 DUnknown
- deced		etec		040 1460 00	24h Wasa	autopsy findings available
+	Recelaw has by 19 2 5	Completed	Chronic renal failure	24a. Was ar autopsy perform	prior t	o completion of cause of
2	The		Maketes, type 2	1 ☐ Yes 2	2546 1 Q Y	es 2 No
9	Vital sicien: T certificat irector, pi	Be	examiner? Hospital: Other	th (Check only one		
\ 1	Of Physe ral di	- To	To tes 21 No 12 Inpatient 2 EN/Outpatient 3 DOA 4 Norsing Re	28d. Describe ho	nce 6 □Other (S) w injury occurred	oecny)
4	On ding h. After fune	tion	M 1 Yes 2 No			
,	Division I or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Str	eet and Number or	Rural Route Number,
	Div	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town	State)	
	Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	, and due to the ca	use(s) and manner	as stated.
	ne Ho 124 l ne Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, da	te and place, and d	ue to the cause(s)
	To the vithin To the comp	Ž	29b. Signature and title of certifier 29c. License number		d. Date signed (Mo	nth, Day, Year)
)		realest Stille m DOON48050		5/10/06	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ŧ	
			frashant Shulda mo 15 South Parke Street Aberda	en mo 2	100	
	_	ate	31. Date filed (Month, Day, Year) 32. Aggistrar's Signature			
	Regist		MAY 1 6 2006 A Section At Specific			
	DHMH 17 Rev 1/3	2001	•			

ORIGINAL

06-03067 James T. George

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	<u> </u>	1- For State Certificate of Death Reg. No. 2005 153	5
Physicia Medical Examin	1//	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year May 6, 2006 1836 hrs	0
		JAMES T. GEORGE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		1344 North Calhoun Street Baltimore City	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) PA 216-74-4312 Usual Residence of Decedent	
any	f	10a. State 10b. County 10c. City, Town or Location 10d Inside City Lim	nits
Aaryland 28a-f show 1 at once,	5	MD BALTIMORE 1 XYes 2	No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the		501 E. PRESTON ST. APT 710 21202 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	_
	Fune	1 X Never Married 2 Married Armed Forces? 1 X Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 3 Widowed 4 Divorced or Dales: 1 Yes, specify: 1 Yes	
ours a	g P	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
D36 thin 72 h ne. than "n	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-00; led with Hygiene other th	Completed	12 MECHANIC SELF 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	JAMES GEORGE SIGRID K. HENRICKSON	
mD 2121 and 2 should be fi lealth and Mental item 27 is marked traumatic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
E da 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2	-	CAROLE BROWN/SISTER 1258 WALKER AVE. BALTIMORE, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	_
교 등 등 등 등		1 Burial 2 K Cremation 3 Removal from State crematory or other place)	
Baltimore, permit. Pages I an Department of Hea Important: If itel injury or other tr	-	4 Donation 5 Other Specify METRO CREMATORY 05-17-2006 BALTIMORE, MD 21. Signature of Fugeral Service Licensee / 22. Name and Address of Facility	_
Dept. Dept. Injin		21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE BALTIMORE, MD 21217	
Physician		Approximate Interview failure. List only one cause of each line. Approximate Interview failure. List only one cause of each line.	
/Medical Examiner	1	Immediate Cause (Final disease a. Cocaine and methadone intoxication	
San Marian San San San San San San San San San S		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
	Je.	if any, leading to immediate Due to (or as a consequence of):	_
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	—
ecuted and transit		d.	
760, icate be exe	eg	X UNPENDED item#23a,27,28a-f,perME,g856,6/16/06 TT	
8760, rificate be ng physici		IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
Box 68's death certificate attending ed for use as	Sicia	4 Pregnant at time of death 5 Other (Specify)	
that the de ned by the detached for	ڇَا م	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death?	\dashv
, P.C res that	<u>چ</u>	1 Yes 2 ✓ No 3 Probably 4 Unknown	n
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eco he law ate has	E I	autopsy prior to completion of cause or performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	1
tal Recian: The certificate	ğ B	25. Was case referred to medical 26 Place of Death (Check only one)	
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n of		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1 Natural 5 Pending 28b. Time of Injury (State of Injury) (Month, Day,Year) 1 Yes 2 XX No 1 Yes 2 XX No	
isio Atten er deat rector by the	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Bural Poute Number Cl.	tv
Divi	Certification;	Suicide 6 A Could not be determined 4 Homicide Homicide (Specify) Roadway Suicide 6 A Could not be determined (Specify) Roadway	<u> </u>
0 0		29a. Certifier (Check only one) 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To the J	Medical	and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	\dashv
		May 7, 2006	
	+	30. Name and address of person who completed cause of death (Item 23a)	\dashv
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr		31. Date filed (Month, Day Year) AAY 1 6 2006 32 egistrar's Signature	

			1 - For State Registrar	State of	Maryland		artment rtificate			and Mental I	Hygier	-24	306	15356
	Physici /Medio		1. Decedent's Name (First, Middle, La WILLIAM LEONA		FFITH					2. Date o Month MAY		ay	2006	3. Time of Death 10:45a M
* Aug	Examir	er	4a. Facility Name (If not institution, given 16924 YORK RD				MON	кто				BAL	nty of Death	
	Funeral Director		217-24-2003	M 2□F	7. Age (In yrs. Ia	Yrs.	If Under Months	Days	If Under a	8. Date of (Month) 01/2	1 Birth Day, Yea 1 / 1 9	28	9. Birthp Coun MAR	place (State or Foreign htry) YLAND
	Maryland -f ahow led at	tor	Usual Residence of Decedent 10a. State 10b. County MD			, Town or Lo							1	0d. Inside City Limits 1 ▼Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 524 WOODLAWN R	D	l		10f. Zip	Code 2 1 2 1	0		10g. 0		of What Coun	ntry?
9036	n 72 hours after death with the Maryland "natural", or Itama 23a or 28a-f ahow adical Examinar must be notified at	ğ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Types 2 If Yes, Give Year or Dat	ces?		Was Deced f Yes, spec 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Specify Yes o , Puerto Rican, etc.	r No-)		lace - Americ lack, White, cify: WHI	etc.
21215-0036	s within jiene. r than	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1- 4YRS	4or 5+)	(Give life.	dent's Usua kind of won DO NOT us ERAL	k done d e retired)	uring most	of working TOR			Business/Inc	,
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	27 le		JOAN GRIFFITH(• • • • • • • • • • • • • • • • • • • •	OOL DI	524	MOOD	LAW		or Rural Route Nu	.,MD	. 2	1210.	•
Baltimore,	Pages ment of mnt: If It ury or c		20a. Method of Disposition 1 ☐ Burial 2 GCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		tate ce	ace of Dispo metery, cren EN MO	natory or ot	her place	1	Date RY05/11			n - City or To JTO CI	
Ball	permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service Licer	and	6	HE	Name and ENRY 5924	W.	JENK	INS & S MONKTO	ONS N,MD	co.	1111.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Self	used the death, ch line.	ed Gu		,		To head	ry arrest,		4	Approximate Interval Between Onset and Death 5 minutes
8760, d	death certificate be executed e attending physicien and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequ									
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of Vit	Physician: this certificatal director, i	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No		-	R/Outpatien			[□] 4 □ Nur		esidence			Parking lot
ion	ending sath. or: After he fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	May 9	Day Year) 2006	28b. Time of Injury 1045	4 M		es 2 X	wou 28t Location	nt lic	tec	head	Shat
οįς	To the Hospital or Att within 24 hours efter de To the Funerel Direct completely filled in by t	al Certi	4 ☐ Homicide	Park	ng Lo	†			a date and	1692	Town, Sta 4 YM YTON	K R	10 ZI	11
	o tha Hos ithin 24 h o tha Fur ompletely	Medical	(Check only one) 2 Medical Example (Check only one) 2 Medical Example (Check only one) 29b. Signature and title of certifier	niner: On the bas and manne	sis of examination	on and/or inv	estigation,	in my op	inion, deatl	h occurred at the tin	ne, date a	nd place	a, and due to	the cause(s)
	84₹4		I his Translatelle	MD	gal	ity	D	18	667		Ma	V 1	0 7	006
_	10		30. Name and address of person who Philip Mil	itello	of death (Item	23a) (Type,	mbl.	e H	:11 c	T. Luthe	بالان	e 1	MD 2	21093
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 6 200	32. Re	gistrar's Somati	ure						•		

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JAMES MCHENRY GILLET 3:00р м MAY 8, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 12A CROSS KEYS ROAD BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months Days Hours Min. DEC. 9, 1927 | MARYLAND 9. Birtholace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2□ F 214-26-0343 78 Yrs Director Usual Residence of Decedent he filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or itema 23a or 28a-f ahnw 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or itema 23a or 28a-f ahow The Medical Examiner must be notified at XXYes 2□No MD BALTIMORE Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12A CROSS KEYS ROAD 21210 USA Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 + SCHOOL TEACHER EDUCATION permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE M. GILLET, JR. SOPHIA STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAIRE STEWART cousin 8606 PARK HEIGHTS STEVENSON, MD 21153 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State THOMAS CHURCH 5/11/2006 OWINGS MILLS, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SOURS (Co. 21. Signature of Funeral Service Licenses WAND 16924 YORK ROAD MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE LUNG DISEASE CHRONIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached f 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2□ No 1 ☐ Yes 2 ☑ No 1 Yes within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 5 Pending 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospitel o within 24 hours eft To the Funeral Di t Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D34827 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) OSLEL DRIVE SUITE 101 7401 32. Registrar's Signature 31. Date filed (Month, Day, Year) 6034 State

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Registrar

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			1 - State Registrar	State of Ma	aryland			nt of He te of D				giene Reg. No		1030	0
	**** A	Decedent's Name (First, Middle, Last)						-			2. Date of De	ath		3. Time of Dea	th
	Physici		Larisa K. Gaas	terland							Month May	13		12:45	РМ
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City	, Town, or	Location	of Death		· · ·	. County of Dea		
			Manor Care-Potoma	ıc			P	otoma	ac				Montgo	mery	
	Funeral		Social Security Number 6. S	ex 7. Ag	e (In yrs. las		If Unde	Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	v Year	9. Bi	rthplace (State or Fo.	reign
-	Director		216-36-0591	LIM ZAIF	67	Yrs.					Sept. 2	5, 1	938 R	ussia	
	and w		Usuaf Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Li	mits
	Aaryii Bho	ō		0.3617	Pot	omac								1 □ Yes 2🗓] No
	28e-	ect	Maryland Montgom 10e. Street and Number	ery	100	Ulliac	10f. Z	ip Code				10a. Ci	tizen of What C	ountry?	
	with Ba or	Funeral Director	8201 Buckspark I	ane West				2085	54			-	United	,	
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. V	Vas Dece			igin? (Spe	ocify Yes or No Rican, etc.)		14. Race - Am	erican Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. I do ther than "natural", or items 23a or 28e-f ahow avent, if a Medical Exaction rougher registed at	by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:		1		ecify Cubar 2 <mark>∭</mark> No	Specify:		Rican, etc.)		Black, Whi		
Ö	2 hou	Completed	15. Decedent's E			16a. Deced	lent's Us	uaf Occupa	tion			16b. F	Kind of Business	s/Industry	
215	c * 1	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	DO NOT	ork done d use retired)	uring mos)	st of worki	ng				
21	gien gien er th	No.		4		Но	mema	ker					Own Ho	me	
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yla	should be filed within and Mental Hygiene. I marked other than umatic avent, tro Mi	ပု	John Kanarchuk						Olg	a Na	rchuk				
lar	2 a = 0		19a. Informant's Name/Relationship (•						or Town, State,		
	s 1 and 3 f Health ltem 27 other tr		Douglas E. Gaaste	rland/husb		8201 B ce of Dispo			ane We		Potomac,		yland 2 .ocation - City or	0854	
0	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Cen	netery, cren Nict	natory or	other place	9)	May	16,	200. L	ocation - City of	Town, State	
ţ	t. Pag rtment rtsnt: I		4 Donation 5 Other (Special	- T	50,		Ce	meter		20	-			New Jersey	
Baltimore,	permit. Pag Department Importsnt: I any injury o		21. Signature of Funeral Average Lices	N	01420	Rc 75.	bert 57 Wi	A. Pur sconsi	mphrey in Ave	y Fune enue,	eral Home Bethesda	/Bet	hesda-Che aryland	evy Chase, : 20814–3501	Inc.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. ne.	Do not ent	er the mo	de of dying	g, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	. Creu	tafe	dt-	Ja	colo	dis	eas	<			Onset and Deat	1
1	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):					-				
н	LAGITIME	_	Sequentially fist conditions,	b								_			
	sit sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
My g g g fat initiated events c.															
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Вох	The law requires that the death certific ate has been signed by the ettending prage 2 should be detached for use as		fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								- 1	23d. Date of de	livery	
ă	death e ette d for	Physician/M	in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	1□Live birth 4□Pregnant at			Ectopic (Other (s	pregnancy pecify)					Month	Day Year	
0	at the de by the	hys	9 Unknown	9□ Unknown											
ď.	es that igned be be det	by P	Part II. Other significant conditions	contributing to death b	out not result	ting in the ur	nderlying	cause give	n in Part I	l.	23e. Did t	obacco	use contribute t	o the cause of death	?
ğ	en sig										1 🗆 '	res 2	□No 3□P	robably 4.2 Unkn	own
Vital Records,	e law requ has been je 2 shouk	Completed									24a. Was		24b. Were a	utopsy findings avail completion of cause	able
Ě	The i	E									perfo	rmed? 2.⊠No	death?		O1
ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?						26. Pface	e of Death	Check only o				
of V	Physic this ce al dire	္	1 ☐ Yes 2 🖔 No	Hospital:		R/Outpatien	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					ecify)			
	ding P. h. After t funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	iry y Year) 2	28b. Time of In j ury		28c. Injury Work			28d. Describe I	now inju	iry occurred		
Sio	Attendi er death. ector: A by the fu	cati	2 Accident investigatio		1		М		res 2 🗌						
Division	or Attendated of the control of the color.	Certification:	4 Homicide determined	286. Place of In	jury - At hom tc. <i>(Specify)</i>	ne, farm, str	eet, facto	ry, office			28f. Location (3 City or Tox	Street a. vn, Stat	nd Number or F e)	lural Route Number,	
	pital ours a eral [29a. Certifier 1 🔀 Certifying Pl	veicien: To the best	of my know	ladge death		d at the time	o data ar	ad place	and due to the		N and		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		nysician: To the best miner: On the basis o and manner st	t examination	on and/or inv	vestigatio	n, in my op	onion, dea	ath occurr	ed at the time,	date an	d place, and du	e to the cause(s)	
	o the	Me	29b. Signature and title of certifier				25	c. License	number			29d. Da	ate signed (Mon	th, Day, Year)	
	⊢ <i>≤</i> ⊢ ō		les.					000	54	566		51	14/06		
é	21		30. Name and address of person who	completed cause of o	death (ftem 2	23a) (Tyne	Print)								
(XT	1	30. Name and address of person who Sunitha Blogar 31. Date filed (Month, Day, Year) MAY 1 6 200	ile: 122	OAS	East	- JO	rna	RM	d	Spoil	22	TOCUS	ON MAD	128
15	- Sta	ate	31. Date filed (Month, Day, Year) MAY 1 6 200	2. Registr	rar's Signatu	re /	مر	1	1100	,		-10	, , , , ,	-10,11152	0(
and in	Regist		MAY 1 6 200	6 Julian	J. St.	Son	(A)								

State of Maryland / Department of Health and Mental Hygiene 006

		•	For State Registrar	Otate of Marylar		rtificate of l			Reg. No.		1000
, 4 ,	Dhuaisi	ų.	1. Decedent's Name (First, Middle, Las			T. 0.111.5.11		2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		CAROLYN		GL	ICKMAN	La contract Description	MAY 12			10:00 PM
	Examin *		4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME 4b. City, Town, or Location of Death BALTIMORE						4c. County of Death BALTIMORE		
**	Funeral		5. Social Security Number 6. Se	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	h (.Year)	9. Birthp	place (State or Foreign
×\$4	Director		212 00 0701	□M 2√ F	97 Yrs.			107037	1908		MD MD
	land ow	}	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	Od. Inside City Limits
	Mary	ctor	MD BALTIMO	RE	BALTI	MORE					1 ☐ Yes 2 🖁 No
	or 28	Direc	10e. Street and Number			10f. Zip Code	01000		10g. Citizen	of What Cour	-
	e 23a	Funeral Director	1450 BEDFORD AVEN	UE #716 12. Was Decedent Ever in I	118 13		21208	ecify Yes or No-	14.	Race - Americ	USA can Indian.
0	riter de	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🐼 No		Was Decedent of H		Rican, etc.)		Black, White,	
2-003p	d within 72 hours after death with the Maryland ilen. Jiene. Then "natural; or iteme 23s or 28s-f show the Madical Examination notified at	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			ecify:	WHITE
ה	n 72 h "natu edice	Completed	15. Decedent's Ed (Specify only highest grade)	de completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ing	16b. Kind o	of Business/In	STORE
7	within liene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		PERSON	,		HOCHS	CHILD-	KOHN DEPT.
B	e filed al Hygie I other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sur	пате)	
yland	ould b Ments arked	To D	JACOB		FARBE		ESTHER				BECK
Mar	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (7)			ng Address (Street: COUNTESS					
-	tem 2		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place		Date		ion - City or To	
Ē	0 0 = =		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		E HEBREW		5/2006	BALT	IMORE,	MD
galtimore,	permit. Pag Department importent: i any injury o		21. Signature of Funeral Service Liften			2. Name and Addres					
	20729		allanan v	Miga	8 Sth. Do set se	900 REIST	ERSTOWN I	ROAD - F	PIKESV	ILLE,	
			23a. Partl. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one duse on each line	5	HILLAR (Love	TA	1631,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a conse	equence of):	Toury		- w			
	Examiner		Conventially list conditions	b	,	9					
4	Z #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
10	tificate be executed ig physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a conse	equence of):						
09/89	e be e sicien e buriz			d							
9	ntificat ng phy as th	Medical	IF FEMALE:								
X R Q	death certificate be executed e attending physicien and of for use as the burial-transit		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe	tal death 3	☐Ectopic pregnancy	,		23d	Date of delive Month	ery Day Year
o.	at the de by the a teched i	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡ Pregnant at time of 9⊡ Unknown	geath 5t	Other (specify)					
2	The law requires that the ste has been signed by the bage 2 should be deteched.	by Ph	Part II. Other significant conditions c	ontributing to death but not re	esulting in the u	underlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to t	he cause of death?
ecords,	w requires been sig should be		189	Miller				101	fes 2□N	lo 3 ☐ Prot	pably 4 Unknown
ဝင္ပ	law re	Completed	18	2 Unleast	m			24a. Was autop	an 2	4b. Were auto	ppsy findings available impletion of cause of
r		Con	14						rmed? 2 No	death? 1 ☐ Yes	2 🗆 No
Vital	sician: Th certificete rector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:								4.1
0	Attending Physician: r death. ector: After this certific by the funeral director,	-	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	☐ ER/Outpatie			28d. Describe			y/
io io	ittending I death. ctor: After y the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □No				
Division of	or Attendential Directorin by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (S City or Tox		umber or Run	al Route Number,
	ours a nerei C	O	29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge, dea	th occurred at the tir	me, date and place.	and due to the	cause(s) an	d manner as s	stated.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai		niner: On the basis of examinand manner stated.							
	To the To the comp	ž	29b. Signature and title of certifier	MO		29c. Licens	se number			igned (Month,	
}	t		100	· · ·		1)2	1167		5//	4100	
	b		30. Name and address of person willo	completed cause of death (II	9m 23a) (Type	, Print)	1838	G	che	20 TI	her Rel
100	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sig	nature	- B)					
	Regist	rar	MAY 1 6 2001	o please to	1. 14.00						

	State of Maryland / Der	partment of Health and Mental	_				
	FOI	ertificate of Death	Reg. No. 2006 5360				
Physician	Decedent's Name (First, Middle, Last)	2. Date	of Death Day Year 1.00				
/Medical	Jacqueline Lucille Horst 4a_Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
Examiner	Franklin Soware Hospital Center	Rosedale	Baltimore				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min. (Month	of Birth h, Day, Year) 9. Birthplace (State or Foreign Country)				
Director	218-42-5171 60 Trs. Usual Residence of Decedent	2/9	/1946 Tennessee				
thow	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits 1 ☐ Yes 2X No				
with the Mar t or 28a-1 st te mutified Director	Maryland Baltimore Middle R	iver	10g. Citizen of What Country?				
death with the Maryland ms 23e or 28a-f show rms 15e or 28a-f show rms 15e rotified at meral Director	1426 Shore Road	21220	U. S. A.				
r death	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					
336 Jis after death v is after them 236 marcher must by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐No Specify:	Specify: White				
- 3 6 EM -	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working	16b. Kind of Business/Industry				
ed within 72 hours hours hours have then "neture it, the Medical E	Elementary/Secondary (0-12) College (1-4or 5+)	o. DO NOT use retired) Cher	Baltimore City School System				
be filed d other.	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M					
Vian Vian Sould be Mental Mental Mental To B	Jack Bowen, Sr.	B. Lucille					
re, Maryland 21215-0 s 1 and 2 should be filed within 72 h thealth and Mental Hygiene. Item 27 is marked other than "netu other traumatic event, the Medical To Be Completee		ailing Address <i>(Street and Number or Rural Route N</i> 26 Shore Road Middle Ri	ver, Maryland 21220				
S 1 and Item 2 theal	20a. Method of Disposition 20b. Place of Dis	position (Name of Date	20c. Location - City or Town, State				
altimore nit. Pages 1 sartment of He outant: if iten injury or oth	1 🗆 Bunal 2 🚅 Cremation 3 🗀 Hemoval from State	rematory or other place) 5/15 Crematory 2006	Baltimore, Maryland				
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiene Important: If them 27 is marked other the eny injury or other traumatic event, Inal pance. To Be Com	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bruzdzinski Funeral Hom 1407. Old Facility	e PA				
	23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	1407 Old Eastern Avenue anter the mode of dying, such as cardiac or respirat	ory arrest, Mary Tariu 2 1 2 2 1 Approximate Interval Between				
Physician	Immediate Cause (Final disease or condition		Onset and Death				
/Medical Examiner	Due to (of as a consequence of):	No do Tillo N	nomeio				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) b. Is Chemic Acute Lubylar Necrosity Could be for as a consequence of the country of the c						
60, be executed ician and burial-transit	Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
3 pri	Phe LIM DIA	a					
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Box ath cer ath cer intendir for use	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy	23d. Date of delivery Month Day Year				
.O. I the de	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)					
Division of Vital Records, P.O. Box 68' the Hospital or Attending Physician: The law requires that the death certificat the Funeral Director: Atter this certificate has been signed by the attending phympletiely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?				
ord requir	Heute Mit		1 Yes 2 No 3 Probably 4 Unknown				
Rec he taw e has I age 2 s			Was an autopsy performed? performed? Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
Vital F ulclan: Th certificate rector, pag	25. Was case referred to medical	26. Place of Death (Check					
Of V Physic this ce ral dire	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		Residence 6 Other (Specify)				
ion nding tth. :: After e fune	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	e of 28c. Injury at Work? M 1 Yes 2 No	and the state of t				
Division of Vital Recomplete to the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)				
pottal of ours at ours at filled i	29a. Certifier 19 Certifying Physician: To the best of my knowledge. 3c	touth oncurred at the time data and plans and due t	the cause(s) and cannor as stated				
o the Hospi thin 24 hou thin Perne impletely fit	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.						
within To the comp	29b. Signature and title of certifier	29c. License number D & Z 3 7 3	29d. Date signed (Month, Day, Year)				
, 5	30. Name and address of person who completed cause of death (Item 23a) (Type						
13	Dr. Robert Paz, 9000 Franklin	1 Square Drive B	altimore, MD. 21737				
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Contes	•				

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:00 at JON DELON HARPER MAY 2 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda National Instutes of Health Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**™**M 2□F Yrs. Director 07 10 1979 Guyana 121-84-2194 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow Examiner must be notified at MD 1¥ Yes 2 □ No Director PRINCE GEORGES Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 5415 85th. Avenue Items 23a 20706 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neture!, or Item eny injury or other traumatic event, the Medical Exercities." Black, White, etc. 1 Never Married 2 Married ☐Yes 2 ☑ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th. Unemployed Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gordon Harper Georgiana Waldron ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 85th. Ave.., Lanham, MD. 20706 Gordon Harper/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-13-06 Wash. D.C. Mt. Olivet Cem. 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Renaz FAILURC 4 DAYS **Physician** /Medical Due to (or as a consequence of): Examiner Renal Coll CA 3 months MEDUILARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the ettending physicien and hed for use as the burial-transit or Attending Physicism: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be Metabolic LActic Actousis 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 No Yes 1 Yes 2)(C) No 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification; 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. VA 0102201431 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EHANDLER AUID 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2006 Registrar

		-	For State	State of Maryland	•	irtment of He			ene2 ()	16	15362
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death
	hysicia		Mari	orie Matilda H	ardin	g		Month May 10	,	Year	8:32 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or L	ocation of Death		4c. County of	of Death	
	. Adıı	•	Ivy Hall Nursing	Home		Midd1e	River				e Co.
Fu	ineral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear)	9. Birthp Coun	lace (State or Foreign
	ector		377-10-0001	M 2 🔀 F 91	Yrs.				,1914		inios
pu	2 E(37	-	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation				1	0d. Inside City Limits
lanyla	sho	5		timore			Dundalk				1 ☐ Yes 2€ No
the N	28e-1	Director	10e. Street and Number	01.11010	-	10f. Zip Code		10	g. Citizen of W	hat Coun	ntry?
with	la or	直	553 Bayside Drive				21222		United	Sta	ites
Daltimore, Interpreting 2.12.3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	TS 23	Funeral		12. Was Decedent Ever in U.S	. 13. \	Was Decedent of His	panic Origin? (Spe	ecify Yes or No-			an Indian,
after	i te		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		f Yes, specify Cuban	Specify:	Hican, etc.)		c, White,	etc.
Since	Exe.	ξ.	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 2 🙀 No	эрөспу.		Specify:	W	Mite
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ithin ne.	han,	Id II	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>00 NOT use retired)</i> teria Wor!	kar		Public		
w bel	her t		12 Years 17. Father's Name (First, Middle, Last)		Care			e (First, Middle, M			
De fi	ever	Be						Lester	andon Comani	2)	45
Tyle	nark	၉	Peter D. Loarie 19a. Informant's Name/Relationship (Ty		19h Mailir	ng Address (Street ar			City or Town.	State Zin	Code)
VICE 12 st hand	7 is r traur	1	Mrs. Betty Lapin			5 Dogwood		Oundalk,			21222
T and Healt	ther	12	20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of			Dc. Location - (
ages nt of 1	or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	-	natory or other place	I	10000	D	, , , ,	141-mil 1 - m A
attimor mit. Pages partment of	njury	1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			of Faith (3/2006	ROSSVI	тте,	Maryland
Depo	any ir		1/7.0		1 .	Duda-Ruck 7922 Wise	Funeral	Home of	Dundal	k, J	nc. 1222
_	-		23a art1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.						Q 2.	Approximate
			shock, or heart failure. List only or immediate Cause (Final	ne cause on each line.		<i>y</i>	6				Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	Due to (or as a conseque	TI C	sters	101	7609	<u></u>	-	(Oyears
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	- 13	ē	Sequentially list conditions, if any, leading to intinediate cause. Enter Underlying	Due to (or as a conseque	mos út).	1147	107			- 2	9
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	ng ph as th	a)	IE EEMALE.								
Geath certific	tendii r use	an/h	23b. was decedent pregnant	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (death 3	Ectopic pregnancy			23d. Date Mor		ery Day Year
ъ в В	been signed by the attending p should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown	ath 5	Other (specify)					,
T at	d by t	Phy	Part II. Other significant conditions con	atributing to dooth but not recul	ting in the u	ndertving cause gives	n in Part I	23e Did toba	acco use contr	ibute to th	ne cause of death?
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E e	oa o	S)iabetes	m	24 Hu		1 ☐ Yes 2	No 1	☐Yes	2 🗆 No
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الم الم	this al dii	2	1 Yes 2 No	1 □ Inpatient 2 □ E	R/Outpatier 28b. Time o	IT 3L DOA	4 Thursing Ho	me 5 Resider			y)
ding	After	lon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work'	es 2 🗆 No		,,		
DIVISION of Attending after death.	the /	Ical	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne, farm, sti			28f. Location (Str.		er or Rura	al Route Number,
Lor A after	Dire In b	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	, , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)		
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After completely filled in by the funera			sician: To the best of my know							
e Ho	e Fui	edical	(Check only 2 Medical Exami	ner: On the basis of examinati and manner stated.	on and/or in	vestigation, in my op	inion, death occur	red at the time, da	te and place, a	ind due to	the cause(s)
To th	To the	Me	29b. Signature and title of certifier	1100		29c. License	number	29	d. Date signed	(Month,	Day, Year)
				you D.	0	A:	3559	3	5/10	12	000
	5		30. Name and address of person who co	ompleed cause of death (Item	23а) (Туре,	Print)		2 ,1		N	1001221
	J		DU JOHN	LOH 112	4 M	HCE M	UE,, 1	314471	MORE	-110	1021221
	Sta		31. Date filed (Month, Day, Year) MAY 1 6 2	32. Angistrar's Signat	ure	last .					
	Regist	rar	mn: 1 0 2	JULI SERVER S	w As	A STATE OF THE PARTY OF THE PAR					

			For State Registrer	State of Ma	ryland / Depa <i>Cel</i>	artment of I			giene	16	15363
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La Aucoluda 4a. Facility Name (If not institution, gh	Holdre	n	4b. City, Town,	or Location of De	2. Date of De Month	Day	Year OOG y of Death	3. Time of Death 7:45pM
	Funeral Director		233-16-6073		enter (In yrs. last birthday) 87 Yrs.	ESS If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Bir (Month, Da OCT. 6,	th	9. Birthpla West	e ace (State or Foreign ^(ry) Virginia
	ne Maryland 8a-f show cliffed at	ector	Usual Residence of Decedent	nore	10c. City, Town or Lo	le Rive	r		10g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 No
	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show ifeal Examinat must be motified at	Funeral Director	3 Right Wing	Drive 12. Was Decedent E Armed Forces?	ver in U.S. 13.	10f. Zip Code 212 Was Decedent of If Yes, specify Cut		(Specify Yes or No uerto Rican, etc.)	USA	ce - America	an Indian,
5-0036	72 hours afte neturel', or It dical Examin	Completed by Fu	1 Never Married 2 Married TWidowed 4 Divorced 15. Decedent's E (Specify only highest gr		16a Dece	1 ☐ Yes 2 ☑ No dent's Usual Occu kind of work done DO NOT use retire	pation	working	Specil	fy: Whi:	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Be Comple	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Las	College (1-4or 5-	Rive		18. Mother's I	Name (First, Middle		me)	
Maryla	nd 2 should be faith and Mental H 27 is marked of r traumatic eve	To	Oren Dayton E 19a. Informant's Name/Relationship Douglas B. McK	(Type, Print)			t and Number or	Jane Sh Rural Route Numb ay 42 We	er, City or Town	, State, Zip (
Baltimore,	t. Pa ntmer ntent njury		20a. Method of Disposition 1 Burial 2 XCremation 3 [4 Donation 5 Other (Special Service Lice	(fy)	20b. Place of Dispo BayVI eV	v Crema		11-100	20c. Location Baltim	ore 1	MD
Ba	permi Depa Impo any ir		23a. Part1. Enter the disease, or conshock, or heart failure. List only	10nn	the death do not en	Connel	ly Fune	300 Mace eral Hom	e of E	Ssex	O.MD 21221 Approximate Interval Between Onset and Death
8760,	auth certificate be executed water certificate be executed attending physician and attending physician and the buriat-fransit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause juisease or injury that intitated events resulting in death) Last	b. Due to (or as a	a consequence of): a consequence of):	Senent	ia.				years.
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and '2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ 100 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pregnand □ Other (specify)	су			ate of deliver onth [ry Day Year
Records, P.	law requires that as been signed b 2 should be deta	Completed by Pt	Par II. Other significant conditions Hypother oid Dialetes	contributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	Yes 2□No	3 Proba	e cause of death? ably 4 (40) by findings available apletion of cause of
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į	Str. Registr		30. Name and address of person who D.A. M. C.M. A. e. 31. Date filed (Month, Day, Year)	1 Sch	eath (Item 23a) (Type,	Print)	0 R:+	chie	11	JAY	BALTO. MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month HART **Physician** MILDRED MOL 12, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERS SILVER SPRING HOW CRUBS HOSATH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-22-1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 80 Yrs Florida Director 076-22-6811 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County rthen "natural", or Itams 23s or 28s-f ehow the Medical Examinat must be notified at MD Montgomery Takoma Park 1 XYes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 8105 Flower Ave 20912 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important: If item 27 is marked other then "natural", or itams 23a empt injury or other traumatic event. The Medical Examinant mosts. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Black It Yes, Give Year or Dates: Specify Specify: Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas DeForest Brown Sarah Ruth Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leisa H. Hart/daughter 8105 Flower Ave Takoma Park MD 20912 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 05-16-2006 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral & Cremation Service 21. Signature of Funeral Service Licensee mu1358 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERCHEBIC RESPIRATORY PAILURE WEST **Physician** /Medical Examiner CHRONIC OBSTRUCTIVE PULMONARY DISMSE 104RC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fr 1 ☐ Yes 2 No Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown DIABETES MELLITUS Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has 2 No 1 Yes 2/2 No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the bast of my knowledge death occurred at the time, date and plane and due to the nausels) and marrier as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 235 Carthier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MY 12, 2006 136252 (ille 30 Name and address of person who Implete mpleted cause of death (Item 23a) (Type, Print 11501 GEORGIA LYE #575, WHOATON MB 20902 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

		-	For State Registrar		State o	of Marylan		artment of rtificate of				giene Rag. No.	06	15365
	Diam'r.		1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Ellie	Gert	trud	Heyc	k]	May 8,	2006		6:00 P M
	Examin		4a. Facility Name (If not institution	n, give st	reet and nu	ımber)		4b. City, Town,	or Location	of Death		4c. Coun	ity of Death	1
			38 Sunnyview		е				enix				1timo	
	Funeral		5. Social Security Number	6. Sex	M 2X)F	7. Age (In yrs.	•	If Under 1 Year Months Days		Min.	Date of Bir (Month, Da	th ly, Year)	9. Birth	nplace (State or Foreign untry)
	Director		213-58-1455	_ ''	W 2001	8	3 Yrs.				April	3, 1923	Ger	rmany
	pur *	-	Usual Residence of Decedent 10a. State 10b. County	,		10c. Cit	ty, Town or L	ocation						10d. Inside City Limits
	sho	5					701	•						1 ☐ Yes 2 💢 No
	the N	Director	Maryland Balt 10e. Street and Number	imor	e		Phoe	10f. Zip Code				10g. Citizen o	f What Cou	intry?
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	eath	era	38 Sunnyview			cedent Ever in U	l.S. 13.	2113 Was Decedent of If Yes, specify Cu		igin? (Spe	cify Yes or No	US - 14. R	ace - Amer	ican Indian,
	ter d	F	1 ☐ Never Married 2 ☒ Mar		Armed F					n, Puèrto F	Rićan, etc.)	B	lack, White	e, etc.
39	ors at	by	3 Widowed 4 Divorce		If Yes, G Year or I	ive		1 □ Yes 27 No	Specify:	:		Spec	Whi	te
ŏ	within 72 hours after death with the Maryland ene. Then "naturel", or Itams 23a or 28e-f show Ite Marical Examiner must be nutified at	Completed by Funeral	15. Deceder			1	16a. Dece	dent's Usual Occu	upation	et of workin	10	16b. Kind of		
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7	filed wi Hygien Sther th	Ö	12		n/a		Nurs	ing Assi				Nursi		
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle,	, Last)					18. Moth	er's Name	(First, Middle	, Maiden Sumi	ame)	
<u>X</u>	should to	ဥ	Albert H	einr	ich	Haup				nna		Palla		
a	and and is m		19a. Informant's Name/Relation				19b. Mail	ng Address (Stree	at and Numb	er or Rura	l Route Numb	er, City or Tow	m, State, Z	ip Code)
	and ealth m 27		Johanna H. Mar	tino	/Daug			9 Old Ho	pkins		. Clari			
Ore	of High		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3	emoval from		cemetery, cre	osition (Name of matory or other pl	ace)	U	ate	20c. Location	n - City or i	lown, State
Ē	Pages ment of lent: If it		`4 ☐Donation 5 ☐ Other (Specify)	0.0			s Cemete	4.	5/13/	06	Phoeni	Lx, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene importent: If item 27 is marked other tren "naturel", or Itams 28a or 28a-1 show Importent: If item 27 is marked other tren. "naturel" or Itams Trust be notified at once, in the marked process.			lary	KLE	W		2. Name and Add Lemmon F 10 W. Pa	uneral donia	L Home Road	, Timor	nium, M	Valle D 21	y Inc.
			23a. Part1. Enter the disease, of shock, of heart failure. Lis	r complic	catio s that	caused the dear	th. Do not er	ter the mode of dy	ing, such as	s cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Fin II			OVA	RIA	S (1)	mee	1				Suset and Death
	/Medical		resulting in death)		Due to	o (or as a consec	quence of):			1				10 mutts
П	Examiner		Sequentially list conditions.	b.										747(11)
4	sit &	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (clisteds) or mady	₹	Due to	o (or as a consec	quence or):							
حدر	and and -tran	хап	that initiated events resulting in death) Last	c.	Due to	o (or as a consec	ruence of):							
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	physi the l	dic		d.										
9 X	death certifica e attending ph d for use as th	Physician/Medical	IF FEMALE:	23	3c. If ves. or	utcome of pregn	ancy			-		23d F	Date of deliv	verv
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?			birth 2 Feta		☐Ectopic pregnan☐ Other (specify)	су				Month	Day Year
o.	the de	ysic	1 □ Yes 2 🛣 No 9 □ Unknown		9□ Unki									
<u>а</u>	v requires that the death baan signad by the atte should be detached for		Part II. Other significant condit	ions cont	tributing to	death but not res	sulting in the	underlying cause g	given in Part	l.	23e. Did	tobacco use co	ntribute to	the cause of death?
ds	uires sign Id be	d by									1 🗆	Yes 2 No	3 🗆 Pro	obably 4 Unknown
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a	icien: Th certificate rector, pag	e Co	25. Was case referred to medic	at					00 Di	L Dooth	1 Yes	2 X No	1 L Yes	2 No
₹		o Be	examiner?	1 .	ospital: 1 _	Inpatient 2] ER/Outpatie	nt 3□ DOA C	thor		(Check only	dence 6 🗆 C	Wher (Spec	nifiz)
of	Phys r this ral di	-	1 ☐ Yes 2 ☒ No 27. Manner of Death	-	28a. Date	e of Injury	28b. Time	of 28c. Inj	ury at			how injury occ		ary)
O	th. : After funer	tio	1 X Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Mo	nth, Day Year)	Injury		'ork? □Yes 2 □	No				
Division	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be	28e. Plac	e of Injury - At h	iome, farm, s	reet, factory, office	е	2			nber or Ru	ral Route Number,
á	after after Dire d in b	Certification:	4 Homicide		build	ding, etc. (Speci	ry)				City of 10	wn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C			nar: On the			th occurred at the ovestigation, in my						
	To the within 2 To the complet	Me	29b. Signature and title of certific	gr /.	1,1			29c. Lice	nse number			29d. Date sign	ned (Month	n, Day, Year)
)	->-0		> Mul	10	LUK	20 1	ro	1	250	929	9	Mass	10,	2006
	10		30. Name and address of person	n who cor	mpleted car	use of death (Ite	m 23a) (Tyne					riay	T ∪ ,	2000
	10		Paul Celano,					St., Tow	son. M	Maryla	and 21	204		
	Sta	ite	31. Date filed (Month, Day, Yea	r)					,		- 100			
	Registr		MAY 1	2000	6	Registrar's Sign	J. As	asser!						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** May 9 9;35 PM Charlotte Harbeson 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 1115 Castle Harbor Way Apt. 1A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F 77 Director 039-18-8069 Sep. 28, 1928 Rhode Island Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "neturel", or iteme 23s or 28s-f show the Medical Exemples must be notified at 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 U.S.A. 1115 Castle Harbor Way Apt.1A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Operator Proctor And Gamble traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be nent of Heelth and Mental Is marked Blanche Charboneau Arthur Hawk ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth item 27 I 101 South Jerome Parkway Glen Burnie, MD 21060 Mr. Michael Harbeson /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 12, 0 ÜBurial 2 Cremation 3 □Removal from State ö permit. Pege Department of important: If eny injury or once. Chesapeake Cremation 2006 4 □ Donation 5 □ Other (Specify) Stevensville,MD. 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funer I Se Second Avenue SW Glen Burnie MD. 21061 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 01 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknow <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, ģ cete has been sig , page 2 should b 2 X10 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000 2□ No 1 Yes 1□ Yes of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes 2 Yo P 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Division 5 Pending Injury efter death.

Director: Aft
d in by the fur 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 6 2006 Registrar

			For State Registrar	State of N	Marylan		artmen			and Me		giene Reg. No.	006	15367
	Physicia (Martin	an	1. Decedent's Name (First, Middle	Haci Hac	dda	way					2. Date of Dea		2006	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, Future Care	gruing	ton			B	Location o	ma	ore	BAL'	unty of Death	
	Funeral Director		5. Social Security Number 222-07-8777 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🖾 F	Age (In yrs. 90	last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min. (8. Date of Birt (Month, Day OCT 1,	1915	9. Birthpl Count DELAW	ace (State or Foreign ARE
	Maryland e-f show	ctor	10a. State 10b. County MARYLAND ANNE A	ARUNDEL		y, Town or Lo		-					10	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	with the	l Direc	10e. Street and Number 606 MILLWRIGHT (CT., APT. 2	1		10f, Zip	Code					of What Count	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If itam 27 is marked other than "natural; or Itams 23a or 28e-f show any injury or other traumatic evant. Ita Medical Exarca at most be rutified at once.	by Funera	11. Marital Status 1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force	nt Ever in U s? X No			dent of Hi	ispanic Origin, Mexican	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)	14. [Race - America Black, White, e	an Indian, etc.
1215-0(within 72 hou ane. Ihan "nature iz Medical E	Be Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4c	or 5+)	(Give	dent's Usua kind of wo. DO NOT us STERE	rk done d se retired	during most ()	t of workin	g	16b. Kind o	of Business/Ind	ustry
Maryland 21215-0036	should be filed and Mental Hygies marked other imarked other imarked want.	To Be Co	17. Father's Name (First, Middle, I						18. Mothe	r's Name KINC	(First, Middle,			
Mary	nd 2 sho lith and l 27 is me r traume		19a. Informant's Name/Relationsh JOYCE A. TSAO /								Route Numbe		wn, State, Zip (Code)
ore,	ages 1 and 2 nt of Health : If itam 27 i		20a. Method of Disposition 1 Maurial 2 □ Cremation		16	Place of Dispo cemetery, crei	sition (Nar matory or o	ne of ther plac	(e)		ate	20c. Location	on - City or Tov	
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		4 Donation 5 Other (Sp. 21. Signature of Foreral Service)		FIEZ	ADOWRII	IRKLE 21 CR	d Addres Y-RU	bofick Hwy.,		ERAL HO		A. E, MD	ARYLAND 21061
.8760, G	Physician Medical	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	eros as a conseq pira	uence of):	1	13	A		respiratory ar	1.		Approximate Interval Between Onset and Death
Divislon of Vital Records, P.O. Box 68	Physicien: The law requires that the death certifica this certificate has been signed by the attending ph rai director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Feta at time of d	I death 3	⊒Ectopic pr] Other (sp						Date of deliver Month	y Day Year
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al Reco	: The law recate has be page 2 sho	Completed									24a. Was autop perfor 1 Yes	sy	prior to com death?	sy findings available apletion of cause of
f Vita	ysicien iis certifii director	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatier	nt 3 DC	Othe	W.70		<i>(Check only o</i> le e 5□ Resid		Other (Specify))
sion o		Certification:	27, Manner of Death 1 A Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation		28b. Time of Injury	М			No 28	8d. Describe h	ow injury oc	curred	
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	the Hospital or Attanding nin 24 hours after death. the Funaral Director: Atte npletely filled in by the fune	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be exeminer: On the basis and manner	s of examina	owledge, death ition and/or in	h occurred vestigation	at the tim , in my op	ne, date and pinion, deaf	d place, ar th occurred	nd due to the d d at the time, d	ause(s) and late and plac	manner as sta	ited. the cause(s)
	To the To the Comp	W	29b. Signature and title of certifier Arm atun	H Ma	cem	M	D 290	License	155	50	3	29d. Date sig	gned (Month, E	2006
	5		30. Name and address of person of Am ATUN	NNAE	(1)	n 23a) (Type,	Print)	$\sim 1p$	thin	8	-, B.	7/10	MD	21217
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signa	iture	sette)	J			,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		partment of I <i>ertificate of</i>			giene 200	6 5368
I	Dhysisi		Decedent's Name (First, Middle, Last,					2. Date of Dea		3. Time of Death P
,	Physici /Medio	al	WA	LTER 1	E	JESS		MAY	4,2006	7/170 M
J	Examin	er	4a. Facility Name (If not institution, give	Street and numbers	2010	40. City, Town,	or Location of Dear	ILE	4c. County of Dea	MORE
	Funeral		5. Social Security Number 6. Sec.	7. Age (În yi	rs. last birthda	Months Days	If Under 24 Hrs		h 9. Bi	rthplace (State or Foreign
	Director		2/6-34-2430 Usual Residence of Decedent	1M 2UF 6	Yrs.			DEC. 1	9,1937	MD.
	yland how		10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
	8a-1 a	ctor	MD BALT	MORE	LAN	5 Dow)N			1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show Imust be notified at	Dire	10e. Street and Number	ins Fran	01/ 6	10f. Zip Code	177H		10g. Citizen of What C	country?
	death me 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	14.8. 1	3. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	
5-0036	be filed within 72 hours after death with the Marylar lat Hygiene. Id other than "natural", or itema 23e or 28e-1 ahow event, the Madical Examiner must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		to nican, etc.)	Specify: U	14)TE
<u> </u>	72 ho "natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Gi	cedent's Usual Occu	during most of wo	rking	16b. Kind of Business	s/Industry
	within 72 lene. than "nai	фшс	Elementary/Secondary (0-12)	College (1-4or 5+)	-	DO NOT use retire	DRIV	ER	445	
פ	al Hyg al Hyg other	BeC	17. Father's Name (First, Middle, Last)			2040	18. Mother's Na	me (First, Middle,	Maiden Sumame)	
ylan	Menta Menta marked	10 E	EARL MOORE	-			GEO	REIA	LINK	
Mar	d 2 sh th and th and 7 le m treum		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	ailing Address (Stree	t and Number or R	ural Route Numbe	r, City or Town, State,	20
ē,	s 1 and f Healt ltem 2 other		20a. Method of Disposition		Place of Dis	position (Name of rematory or other, pla	(1) V3 /	Date 8	20c. Location - City of	
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Balti	permit. Dependimport. any inj		21. Signature of Juneral Service License	Skarla	8.	22. Name and Addr	ess of Facility	2529	HUDSON MB	2724
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28	tificate ig physi as the	edical		I						
ŏ	death cert e attendin d for use		230. Was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		3 □Ectopic pregnanc	ev		23d. Date of de	,
	the dea by the at ached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
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DIVISION	at or Att s after de il Direct od in by t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Control of the C	home, farm, cify)	street, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physicien: The law within 24 burus after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge de nation and/or	all occurred at the ti investigation, in my	ma, date and place opinion, death occu	and due to the curred at the time, o	rause(s) and manner a date and place, and du	e stated. e to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier	a Att	tend	29c. Licen:			29d. Date signed (Mon	th, Day, Year)
5	1		Muld	ش <i>ت</i>	MA	D3	6942	- /	May 10,	2006
1	/	il.	30. Name and address of person who co	mpleted cause of death (It	Freel	e, Print)	a. Cato	ystle.	, MD 2,	1228
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig		Locall .				
	Registr	वा	MAY 1 5 2	UUU MARAGO	AS A	CONTRACTOR OF THE PARTY OF THE				

			1 - For State Registrar	State of Maryla		artment of tificate of			giene Reg. No. 2	006	15369
	Physici /Medio Examin	al	Decedent's Name (First, Middle, La PAUL Au Facility Name (If not institution, given the content of the		5,	AMES 4b. City, Town,	or Location of Deal	2. Date of Dez Month MA Y	13	2006 hty of Death	3. Time of Death 0236 AM
	Funeral Director		5. Social Security Number 6. S	13 3 4 Y V E	YEDICAL last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs		h /, Ye <i>ar)</i>	Count	
Mandand	a-f show	ctor	10a. State 10b. County Md. Baltin		ity, Town or Lo Dundalk					10	ld. Inside City Limits 1 ☐ Yes 2X No
the chief	or iteme 23s or 28s-1 show	ral Director	10e. Street and Number 7801 Vietnam Vet			10f. Zip Code 212.				SA	
C Pourse after death with the Macadana	el', or item Examinar	by Funeral	11. Marital Status 1 □ Never Married 2 🏋 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in t Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cu □ Yes 2 X No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ace - America lack, White, e sity: Whi	tc.
de arithio 73 hours at		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	OO NOT use retir	ed) most of wo	orking		Business/Ind	ustry
1 to 4 to	ental Hygi ked other ic event,	To Be Co	12 yrs. 17. Father's Name (First, Middle, Last) Earl James		Br	ricklaye:		me (First, Middle, rine Bra		teel ame)	
	Health a em 27 is ther tra		19a. Informant's Name/Relationship (Pauline James 20a. Method of Disposition	wife 20b.	780		and Number or R	ns Parkw		to. Md	. 21222
1 agost 1	ant:	İ	1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Specification 21. Signature of Fine II Service Lices	()	ak LAwr	Name and Add	May	717, 2006 Iome Of D		imore	
f	hysician		23a. Part / Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the dea one cause on each line.	th. Do not ente		ers Point ing, such as cardia				Approximate Interval Between Onset and Death
be executed	Medical xaminer parisher and the price transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	Obst quence of): udati quence of): nance	1	e Pulmi	onany D Affusion	is a se 15		24 hours
at the death conficate		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	ancy al death 3 🗆	Ectopic pregnand Other (specify)	су			ate of deliver	y Day Year
	been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	derlying cause g	iven in Part I.		bacco use con	ntribute to the	cause of death?
The law re	ete h page	Completed						24a. Was a autops perfor	sy	prior to com death?	sy findings available pletion of cause of
dor Attending Physician: The law requires	ith. : After this certifice e funeral director, p	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	ther: 4 Nursing H	ath Check only or Iome 5 Residence 28d. Describe he	ence 6 🗆 O		
tal or Attac	Dir	Certification:	3 Suicide 6 Could not by determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (S. City or Town		nber or Rural	Route Number,
he Hospital	in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one)	ysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death ation and/or i <i>n</i> v	occurred at the t estigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and n ate and place	nanner as sta , and due to t	ted. he cause(s)
ToT	within To the comple	Σ	29b. Signature and title of certifier			29c. Licen	se number - 000	2	9d. Date sign	ed (Month, D	ay, Year)
7	Sta Registr		30. Name and address of person who LIPIKA SAMA(, 31. Date filed (Month, Day, Year) MAY 1 6 2	MO 4940	m 23a) (Type, F	Print) ERN AV	FNUE	BALTIM	I OR E,	MD	21224

06-03248 Robert Bruce Jewett

Please Type or Print in Black Indelible Ink

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State of N	Maryland	d / Depar	tment of	Health and	Mental	Hygiene

			l- For State Registrar		tificate of	Death	itai riygic	Reg. No	200	15 1537
	Physici	an/	Decedent's Name (First, Middle,Last)					te of Death	Year	3. Time of Death
Medi	ical Exami	iner	Robert Bruce Jewett, Sr	•			Ma	y 14, 2006		0517 hrs
			4a. Facility Name (if not institution, give street and r 329 Rose Avenue	iumber)	44	c. City, Town, or Location Glen Burnie	of Death		c. County of Dea Anne Arunde	
0	* Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)		der 24Hrs. 8, D			irthplace (State or
9	Director		220-48 - 3060 1X M 2 F	51	Yrs.	Months Days Hour			Fore	ign
			Usual Residence of Decedent		115.			04/17/1	.955	(ountry) MD
	any		10a. State 10b. County	10c. City,	Town or Locatio	n				10d. Inside City Limits
	Maryland 28a-f show d at once.	5	MD Anne Arundel	G1	len Burn	ie				1 Yes 2 XNo
	Maryl. 28a-f d at o	Director	10e. Street and Number	•		10f. Zip Code		10g. Ci	tizen of What Co	untry?
	h the 3a or otifie		7539 Baltimore Annapolis	Blvd.		21060		U.S	S.A	
	th with ems 2 the n	Funeral	11. Marital Status 12. Was De 1 Never Married 2 Married Armed I	cedent Ever in U.S		Decedent of Hispanic Ori s, specify Cuban, Mexican			14. Race - Ame White, etc.	erican Indian, Black,
	er dea	ᆵ	1 Yes	2 X No				,,		
	ırs aftı ural"	2	3 Widowed 4 X Divorced If Yes, Give Ye or Dates: 15. Decedent's Education (Specify only highest grades)			Yes 2 X No specify		one 16h	Specify: W. Kind of Business	hite
	72 hou	Completed		(1-4 or 5+)		st of working life. DO NOT		100.	Talle of Beelings	on industry
Š	036 ithin in in in in in in in in in in in in i	du	12		Superv	isor		L	ong Fen	ce Co.
	5-0 iled w Hygie othe		17. Father's Name (First, Middle, Last)	•		18.Mothe	er's Name (First,	Middle, Maider	Surname)	
Ş	121 d be f lental arkec		Raymond F. Jewett		1.00 1.00	He1	en Virg	inia Ba	ker	
6	Baltimore, MID 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department and Mental Hygeine Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	la	1	Address (Street and Nur				
	and 2 lealth lealth traum		Mr. Charles Jewett / bro		lace of Dispositi	ennington Long (Name of cemetery)	ane; Se		ark, MD Location - City of	
	Ore ges 1 it of H other		1 X Burial 2 Cremation 3 Removal	IOITI Otato	rematory or othe		5 00 0	l	,	,
	it. Pa		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Mea		e Memorial				
Ċ	Depa Depa		Mark 1 V	Mo13.	1 1	econd Ave S				
	Physician		23a. Part I. Enter the disease, or complications that				-		-	Approximate Interval
	/Medical	7	failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotion	c (heroin)	and alcoh	ol intoxicatio	om			Between Onset and Death
	Examiner			a consequence of)			-			
		ايا	Sequentially list conditions, b.							
		ju	cause. Enter Underlying Cause	a consequence of)):					
1	₩	Examiner	(Disease or injury that initiated events resulting in death) Last	a consequence of)):				-	
7	xecute	ᇙ	d	i+cm#1 23	20 27 290	f,perME,g856,6	/20/06 75	п		<u> </u>
	760, Toate be executed sphysician and the burial - transit	Medical				1,penul,g800,0	0/20/06 1.			
1	68 / 60, certificate be nding physic se as the bur		3b. Was decedent pregnant in the	outcome of pregn birth		I death 3 Ectopi	ic pregnancy	23	d Date of delive Month	ry Day Year
	law requires that the death certificate been signed by the attending 2 should be detached for use as	Physician		nant at time of dea	th =	(Specify)	p 3 ,		WOTEN	ou, rou
Ċ	BOX ne death c the atten ned for us	ş	1 Yes 2 No 9 Unknown 9 Unkr	The second secon						
	that the detacl	by F	Part II. Other significant conditions contributing	to death but not re	sulting in the un	derlying cause given in Pa	art I. 2			the cause of death?
_	atuires en sign	ed					— L			bably 4 🗹 Unknown
	aw rei	ble						4a. Was an autopsy	prior to	utopsy findings available completion of cause of
	The Cate Page	Completed					1[performed? ✓ Yes 2 N	death?	es 2 No
	tal cian: certifi ector,	8	25. Was case referred to medical examiner?			26 Place of Death	(Check only or	e)		
2,3	Physi er this	입	1 Yes 2 No		ER/Outpatient		Nursing Hom		ence 6 🗸 Othe	er: Scene
	ding h fune	ë	1 Natural c (Mont	h, Day,Year)	28b. Time of Inju	ury 28c. Injury at World 1 Yes 2 X	a	Describe how inj	ury occurred	
	IVISION I or Attend after death Director: d in by the	cati	2 Accident Investigation		unk	factory, office building, e		neation (Street	and Number of D	Do do Number O'A
č	UNISION OF VITAL RECORDS, P.O. and or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by let funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Certification:	Suicide O A Could not be	Home	me, raim, street,	ractory, office building, e	G1er	Town, State)	Rose A	ural Route Number, City Venue
	DIVISION OF VITAL the Hospital or Attending Physician: hin 24 hours after death the Funeral Director: After this certif appletely filled in by the funeral director,		4 Homicide 29a. Certifier 1 Certifying Physician: To the be		e death occurre	d at the time date and pla				
	UIVISION Of VITAL RECORDS, P.O. BOX 68 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) Medical Examiner: On the basis	of examination an						
	To Wit	Me	and manner 29b. Signature and title of certifier	olateu.		29c. License number		29d	Date signed (Mo	onth, Day, Year)
			()/ antorbers.	()		O.C.M.E.		Ma	y 14, 2006	
	6		30. me and address of person who completed c	of death (Item 2	23a)	1		-		
((2)		Laron Locke MD. Assistant Medic	al Examiner	111 Penn S	Street, Baltimore, M	ID 21201			11.4
		ate		egistrar's Signatur	e South	,		· ·		
	Regist	ırar	7,00	- ,	a second					

06-03137 Amos Jones

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State legistrar		Cer	tificate of	Death			Reg. No.	2 U L	10 1001
Physician	1/	Decedent's Name (First, Middl	le,Last)					Date of De Month	eath Day	Year	3. Time of Death
Medical Examin		Amos		mes				May 9, 2	2006		1629 hrs
	ľ	4a. Facility Name (if not institutio Sinai Hospital	n, give street and numl	ber)	2	Baltimore	or Location of I	Death	4c.	. County of Dea	th
Funeral Director		5. Social Security Number		. Age (In yrs. la	_	If Under 1 Ye Months Da	ear If Under 2 ays Hours	Min.		Fore	
Director	_	38-53-3746 Usual Residence of Decedent	1 M 2 F	4	Yrs.			Marc	hal	1959	ountry) NY
/ any		10a. State 10b. County		10c. City,	Town or Locati	on					10d. Inside City Limits
Maryland 28a-f show any d at once.	2	MD			Bal	timo	re		40	()))//	1 Lyes 2 No
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f sho	Funeral Director	10e. Street and Number	hester	Bd		10f. Zip Code	07		Tog. Citiz	zen of What Co	untry?
death with r items 2:	unera	11. Marital Status 1 Never Married 2 M	12. Was Deced					i? (Specify Yes or f Puerto Rican, etc.)	10-	14. Race - Ame White, etc.	erican Indian, Black,
ral", o			orced If Yes, Give Year or Dates:			Yes 2				Specify: B	lack
"natu		 Decedent's Education (Spe Elementary/Secondary (0-12) 	College (1-4			s Usual Occup est of working li		nd of work done se retired)	16b. K	Kind of Busines	s/Industry
5-0036 led within 72 hours after Hygiewe "hattman" "hattman" "hattman" the Medical Examiner	Completed	1.9	3 (_	Brea	lesta	ate		R	eales	state
215-0036 be filed within 7 ntal Hygiene. rked other than eut, the Medica		17. Father's Name (First, Middle	, Last)				18.Mother's	Name (First, Middle	, Maiden	Surname)	
212 ould be Menta marke c eveu	a e e	19a. Informant's Name/Relations	ship (Type, Print)	wan	19b. Mailing	Address (Str	eet and Number	er or Rural Route N	umber, Ci	ity or Town, Sta	te, Zip Code)
MD and 2 sho alth and m 27 is an an ati		Sarah Hal	1		4001	Don	rches	ster Ro	B	alto,	mD 21307
Baltimore, MD 21215-00; permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Mental Inc.		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from		Place of Disposi crematory or oth		cemetery,	Date	20c. 1	Location - City o	or Town, State
Baltimore, permit Pages I an Department of He Important: If ite	-	4 Donation 5 Other S		$ \mathcal{U} $	letro	ame and Addre	ess of Facility	5-19-01	<u> </u>	alto) MID
Balti permit Departu Import injury		lemos	Tha	wh	II		32M	id-Valler	Dr.	Jesus	PA 18434
Physician	ľ	art I. Enter the disease, or ailure List only one cause				ne mode of dyir	ig, such as care			ock, or heart	Approximate Interval 8etween Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		PIAG COL	u i ovascu	ar disca	se se	ascular dis	2050		Death
		Sequentially list conditions,	b								
		if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c	consequence o	f):						
= 5 4		events resulting in death) Last	Due to (or as a c	onsequence o	f):						
freate be executed gphysician and the burial - transit	n/Medical	X UNPENDED	X AMENDED	item#23a	PII,27,1 perME,g8	erME, <u>g</u> 85	7,7/27/0	6 TT		·	
8760, tificate bo	ě į	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, ou	itcome of preg	nancy					d. Date of delive	
00 15 2 2 1	iciar	past 12 months? 1 Yes 2 No 9 Un	4 Pregnai	nt at time of de	oth -	tal death (ner (Specify)	Ectobic b	pregnancy		Month	Day Year
the dear	Physicia	Part II. Other significant condi	3 OTINTION		esulting in the u	nderlying caus	e given in Part	I. 23e. Dio	tobacco	use contribute t	o the cause of death?
rds, P.O.		End-stage ren				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3	-			obably 4 🗸 Unknown
ords, w requir	ee							24a. Wa	as an lopsy		autopsy findings available completion of cause of
Recol The law icate has	Completed by								formed?	death?	·
of Vital Recing Physician: The Affer this certificate Uneral director, page	Be C	25. Was case referred to medica examiner?	. Hoppitali .				1Othor	Check only one)			
f Vir Physic er this tral dir	၂၂	1 ✓ Yes 2 No 27. Manner of Death		patient 2	ER/Outpatient 28b. Time of I	La	Other;	Nursing Home 5 28d. Describ			er:
ion of verting ph. eath.	ţi	1 X Natural 5 Pen	28a. Date of (Month, I	Day,Year)			Yes 2 N		0 11011 11.30	ary coodinod	
Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si stell filled in by the funeral director, page 2 should be	Certification	3 Suicide 6 Cou	estigation 28e, Place ermined (Specify)	of Injury - At h	ome, farm, stree	et, factory, office	e building, etc.	28f. Location or Town		ind Number or F	Rural Route Number, City
hou hou			Physician: To the best aminer: On the basis of								
To t with To t	Medical	29b. Signature and title of certifi	and manner sta	nted.			nse number				onth, Day, Year)
		The de	11 Z.	V	0	0.0	C.M.E.		May	10, 2006	
	-	30 Name and address of persor		`	,			4D 04057			
		Theodore King MD.	Assistant Medic	istrar's Signati		nn Street, E	Baltimore, N	/ID 21201			
Sta Registi	17.	31. Date filed (Month, Day, Year)	35	istrar's Signati	ure	E					

			1 - For State Registrar	State of Maryland / I	Department of Health and Certificate of Death	Mental Hygien Reg. N	2000 100/6
	Physici	an	Decedent's Name (First, Middle, I	ast) Vo	0	2. Date of Death	3. Time of Death
	/Medic Examin	cal	4a. Facility Name (If not institution, g	monde he	4b. City, Town, or Location of Dea	5-9-	Ic. County of Death
			5. Social Security Number 6	Nursing Home	Baltino	P Date of Righ	O Pichalas (On a S
М	Funeral Director		212-86-2674	1 M 2XIF 30	Yrs. Months Days Hours Min		9. Birthplace (State or Foreign Gountry)
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	the Mar	ector	MD	Ba	Itimore		1 Aves 2 No
	th with	al Dir	1706 E.315+	Street	2J2J8	10g. C	Citizen of What Country?
9036	72 hours after death with the Maryland naturel', or Itama 23a or 28e-f ehow alcal Exantrar must te incliffed al	d by Funeral Director	11. Marital Status Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer 1 Yes No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
215-0036	d within 72 hours jiene. r than "naturel" ite Medical Ex	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education 16a rade completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b.	Kind of Business/Industry
ld 21	at a H	0	17. Father's Name (First, Middle, La	st)	18. Mother's Na	me (First, Middle, Maide	on Sumame)
Maryland	d Mental d Mental narkad c	을(George Jorg	lan _	Deb	orah K	ee
ď	s 1 and 2 should if Health and Mer Item 27 is marka other traumatic		19a. Info S's Name/Relationship Flora Hollon 20a. Method of Disposition	d (Grandnother)	D. Mailing Address (Street and Number or R 1706 E. 315+ 5 If Disposition (Name of	+ Balk	cor Town, State, Zip Code) MD 2 12 18 Location - City or Town, State
Baltimor	Page nent o ant: If ary or		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Hemoval from State	ry, crematory or other place) Memorial Fack 5	/13/06 Ba	Uto.MD
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lic	Sur >	28. Name and Address of Facility	ene Fra	peral Services
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final			c or respiratory arrest	Approximate Interval Between Onset and Death
1	nysician /Medical Examiner		disease or condition resulting in death)	a. HUMM IMM		of Sapp	ROME SISSIAND BOOM
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	of):		
	ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	of).		
68760,	licate be executed physician and s the burial-transit	dicalE		d			
	certifica iding ph		IF FEMALE:	23c. If yes, outcome of pregnancy			
P.O. Box	that the death certified by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Dther significant conditions	contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	0 = 0	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vita	siclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	04	ath (Check only one)	
-	ng Phys ifter this ineral di	on; To	1 Yes 25 No 27. Manner of Death 1 Watural 5 Pending	28a. Date of Injury 28b.	Itpatient 3 DOA Wursing F Time of njury 28c. Injury at Work?	lome 5 Residence 28d. Describe how inju	
Division	To the Hospitel or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be are Bloom of lainer At here for	M 1 Tyes 2 No	28f. Location (Street a	and Number or Rural Route Number,
۵	pitel or ours aft eral Di filled in				o, death occurred at the time, date and place	City or Town, Star	
	the Hos tin 24 h the Fun opietely	edical	(Check only 2 Medical Exone)	aminer: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occu	irred at the time, date ar	s) and manner as stated. Individual place, and due to the cause(s)
	with To	Σ	29b. Signature and title of certifier	D. B. (el	29c. License number	29d. Di	ate signed (Mghth, Day, Year)
	8		30. Name and address of person wh	completed cause of death (Item 23a)		MORE,	1 <1 < 8 coa) Yaan
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2	32 Registrar's Signature	Coole)	7 212 (

			1 - State Registrer	State of Maryland		artment of H			giene 20	06	15373
# S	Physici		1. Decedent's Name (First, Middle, Last) Ruth Janet Lil	perto				2. Date of De. Month May	ath _) 06	3. Time of Death 5:20 A M
	/Medic Examin		4a. Facility Name (If not institution, give so Joseph Richey Hos			4b. City, Town, or Balt	Location of Death	h	4c. County	of Death	
	uneral irector		212-22-9120	7. Age (In yrs. Id M 2 XF		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June /	, 1925	Coun	lace (State or Foreign try) yland
Maryland	-f ahow ling at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		Town or Lo					1	0d. Inside City Limits 1 Y Yes 2 □ No
with the	a or 28e	Direc	10e. Street and Number 4201 Old Frederick			10f. Zip Code 2122	10		10g. Citizen of V		try?
at yid III G G L C I 3-0030 should be filed within 72 hours atter death with the Maryland and Manial Hydiene.	if the 27 is marked other than "natural", or theme 23a or 28e-f ahow or other traumatic event, the Modical Examinat must be nutified at	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Vas Decedent of Hir f Yes, specify Cubar I ☐ Yes 2X No		pecify Yes or No to Rican, etc.)	- 14. Race Blace	e - Americ k, White, c	etc.
within 72 hou	than "natura he Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation	(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired, OMEMAKET	uring most of wor	rking	16b. Kind of Bu	isiness/Ind	
d be filed	ed other	Be	17. Father's Name (First, Middle, Last) William Heim			Omenaker		ne (First, Middle,	Maiden Sumam		
2 should	is mark raumatik	2	19a. Informant's Name/Relationship (Typ			ng Address (Street a	nd Number or Ru	ıral Route Numbe	er, City or Town,		
FINOTE, IN Pages 1 and	Importent: If Item 27 is any Injury or other tran		Anthony Liberto, Ho 20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. Pl	ace of Dispo	Old Frede sition (Name of natory or other place	9)	Date	20c. Location -	City or To	wn, State
Date In Pages Department of	Importent: any Injury once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Utense Thomas Gregor	Me	25	ematory I	Society	Of Mary	land Inc		Maryland
	5 E E G		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death	2	99 Freder	ick Road	d Baltim	ore, Mar	ylan	d 21228 Approximate Interval Between
/M	sician ledical aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ence of):	's Deme	entia				Onset and Death YEARS
J.	* 42	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ierica of).						
o / ou C	ohysicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequ	ience of):						
the death certific	ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 [Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delive	ory Day Year
The law requires that the	s been signed by should be deta	by	Part II. Other significant conditions conf	ributing to death but not resu	ilting in the ur	nderlying cause give	n in Part I.		obacco use conti Yes 2□No	ribute to th	e cause of death? ably 4 ØUnknown
The law re	ate hes bee page 2 sho	Completed						24a. Was autor perfo 1 🗆 Yes		Vere autoportor to con leath?	psy findings available inpletion of cause of
VICAL /siclan:	s certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatien	t 3□ DOA Othe		ath Check only o		er (Specify	Hospice
nding Phy	To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			now injury occurr		7 1100
DIVIS alor Atte	od in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or Tov	Street and Number vn, State)	er or Rura	Route Number,
ne Hospit	ne Funere pletely fille	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	icien: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	a, and due to the urred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
To th	To th	W	29b. Signature and title of certifier			29c. License			29d. Date signed		
6			30. Name and address of person who con	11 1	23а) (Туре,	Print) Entan S	+ Ba	ltimere	MD 2	1201	0
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 20	22 Gegistrar's Signat	UF9	ow					

			State of Maryland / Dep 1- State Amend Item#20a per FH G855 5/23	artment of Health and Me	ental Hygien	2006 15374
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physic /Medi		David F. Logan		Month Da	
7	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
1			Sina Hospital of Baltimore	Baltmore C	145	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Year)	9 Birthplace (State or Foreign
	Director		215-28-3220 1X M 2□F 75 Yrs.		Dec. 18, 1	930 Maryland
. —	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or U	ocation		10d Incide City Limite
,	faryla •ho	ö				10d. Inside City Limits 1 ☐ Yes 2 ※ No
	the N	Director	Maryland Baltimore	Nottingham	10.0	
	with	급		10f. Zip Code	10g, Ca	itizen of What Country?
	eath	Funeral	9019 Tammy Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispania Origin ² (Spec	ify Yan or No	U. S. A. 14. Race - American Indian,
4.0	ler d	Ē	1 Never Married 2 Married 1 Married Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White, etc.
38	urs al		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates 1951 – 1954	1 ☐ Yes 2 No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f ehow ha Madical Examinat must be notified at	Completed by	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b. H	Kind of Business/Industry
215	hin 7	E e	(Specify only highest grade completed) (Given life. Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	9	
2	filed with Hygiene. Ither ther	5		lity Control Inspec	tor A	merican Can Company
nd	be filed tal Hygi d other	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	First, Middle, Maider	n Sumame)
<u> </u>	ould be Mental Marked o	2	James Logan	Mar	garet A.	Grouling
Maryland	AS DE E			ing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
	permit. Pages 1 and 2 Depertment of Heelth a Important: If Item 27 is eny Injury or other tre once.			Tammy Road, Nottin	gham, Mar	yland 21236
Baltimore,	of Hor		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20cemetery, creation 3 □Removal from State	osition (Name of matory or other place) 05/22/	200. L	ocation - City or Town, State
Ē	Pag ment ant: ury c		4 ☐ Donation 5 ☐ Other (Specify) Garrison	Forest Vets. Cem.	Owin	ys Mills, Maruland
alt	Depertr Depertr Imports eny Info		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Schi	munek Fun	eral Homes
<u> </u>	89 5 9		Camaril 9	705 Belair Road, No	ttingham,	Maryland 21236
П			23ar Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Pnysician	0.0	Immediate Cause (Final disease or condition			Onset and Death
1	/Medical		resulting in death) a Due to (or as a consequence of):			1004
	Examiner		Sequentially list conditions. b. reval insuf	francy		1 day
	p ==	ner	f any, leading to immediate cause. Enter Underlying Cause, Disease or injury			- 1
	ocute nd trans	Examiner	that initiated events C.			
Ö,	The law requires that the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	m	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be ex physicien s the buria	dicai	d		-	
9	eath certific attending p	Mec	AF FEMALE:			
Вох	ath co	Physician/Me	23b. Was decedent pregnant 1 ⊆ Live birth 2 ☐ Fetal death 3	∃Ectopic pregnancy	T.	23d. Date of delivery
-	e de	SIC	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 [9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month Day Year
P.O.	that the de led by the a detached i	Ph				
JS,	signed be de	þ	Part II. Other significant conditions contributing to death but not resulting in the t	inderlying cause given in Part I.		use contribute to the cause of death?
oro	w requir	eted	Masures mail. 145		1 Yes 2	□ No 3 □ Probably 4 ☑ Onknown
ec	e law hes b	Completed	Stroke		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
프		S	ahal tibrilation		performed? 1□ Yes 2 No	death? 1 ☐ Yes 2 ☐ No
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of Vital Records,	shys this al dir	ို	1 ☐ Yes 2 No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatie		5 Residence	
Ž.		Certification:	27. Manner of Death 1,⊠Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	d. Describe how injur	ry occurred
Division	Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Σ	or Attendate after death Director:	ŧ	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	f. Location (Street an City or Town, State	nd Number or Rural Route Number, e)
	pital ours a erel l		29a. Certifier 1 Certifying Physician: To the best of my knowledge deal			
	Hos 24 ho Fun stely	lica	(Check only 2 Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and place, and vestigation, in my opinion, death occurred	d due to the cause(s) at the time, date and) and manner as stated. I place, and due to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		ite signed (Month, Day, Year)
	E 3 F 8			80.0014.00	-1	1
	0		20 No.	BS 9316527]]]]	14/2006
10	•		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	CR1	1
1	- Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ma mospital	ot Pal	ZZJOWA
	Registr	_	MAY 1 6 2006 Degree Is A	Print) Shai Hosp. Fal		

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death	75
	Physici /Medi		1. Decedent's Name (First, Middle, Last) OTTO Lockman 2. Date of Death Month Day Year MAY 9 2006 11:30 A	
,	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. County o	aign
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	
	a or 28a-f	Funeral Director	100. Street and Number 101. Zip Code 102. Street and Number 102. Street and Number 103. Citizen of What Country?	4 0
036	urs after deatl	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Specify: 1 Ye	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Itema 23a or 28a-f ehow enty follow other traumatic event, the Mudical Examinat must be notified at ance.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) A RORKE CHURGH	
Maryland 3	should be filed nd Mental Hygi marked other imatic event,	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBELT LOCKMAN MENY ELEZ LOCKAW	
	1 and 2 s Health ar em 27 is ther trau	2073	19a. Informant's Name/Relationship (Type, Prior 55 NDL) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) COMM. ON AGING LUCAS 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)	
Baltimore,	permit. Pages Depertment of I Important: If It eny injury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Poperal Service Ligensee 22. Name and Address of facility 23. Name and Address of facility 24. Donation 5 Other (Specify)	
Ba	Dermi Depe Impo	K 9	I homan sparse SKARDA Fit Drago MD. 25224	
i	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of):	
8760,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either U deitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
P.O. Box 68	eath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Ectopic pregnancy 23d. Date of delivery Month Day Year 9 Unknown	
rds, P	w requires that the di been signed by the should be deteched	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dinknow	٧n
		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No	le
	Physicia this certi al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	
sion (After funer	ertification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	
N N	2 2 2 2	O	4 Homicide determined determined determined building, etc. (Specify) 289. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical	29a. Certifier (Check orly one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	S 7 % 7		29b. Signature and title of Shifter 29c. License number 29d. Date signed (Month, Day, Year) P 5 7 7 2 2 MAY 11 2006	
3			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	\dashv
Ĭ	Sta Registr	te ar	MAY 1 6 2006 LEONARD RICHARDSON M.T. 1838 GREEN TREE RUAD SUITE 300 PILLESVILLE MD 21208	

Stat

te of Maryland / Department of Health and Mental F	lygiene	2006	1537	6
Certificate of Death	Reg. No.	2000	1001	O
	0.00.00.00			

Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death	, 2006 1537			
Medical Examiner Warren Milton Lowery May 11, 2006	1635 nrs			
	c. County of Death Anne Arundel			
	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or			
Director 213-32-3091 1Xm 2 F 70 Yrs. Months Days Hours Min. MAR 5 19.	Country) MD			
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d Inside City Limits			
Bus I MD Ammo Arrivedol Drecol-less	1 Yes 2 No			
model Brooklyn MD Anne Arundel Brooklyn 106. Street and Number 5200 Ritchie Highway, Rear 21225	tizen of What Country?			
purple of the pu	JSA			
12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	 Race - American Indian, Black, White, etc. 			
9 5 日 日 1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 54-56 1 Yes 2 X No specify:	Specify: White			
98 of the standard of the stan	Kind of Business/Industry			
9 College (1-4 or 5+) 18. Mother's Name (First, Middle, Maider 19. Main and Middle, Maider 19. Main and Maider 19. Main and Maider 19. Main and Maider 19. Main and	Transmoutation			
TITUCK DITVEL 18.Mother's Name (First, Middle, Maider 18.Mother's Name (First, Middle, Maider	Transportation n Surname)			
See and the state of the state				
Warren Milton Lowery, Sr. Minnie Moody				
Data Tribing RTISOTI daugitet 200 Old RIVerside Road, Bartino 20c. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c.	Dre, MD 21225 Location - City or Town, State			
20c. Near to do to Disposition (Name of cemetery, crematory or other place) 1	Beltsville, MD			
21. Signature of Fuperal Service Licensee 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, P.				
M00986 8717 Green Pastures Drive, T Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shi	Towson, MD 21286 1			
/Medical failure. List only one cause on each line.	Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death) a Contact Gunshot Wound of Head Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):				
Solution of the state of the st	Bd Date of delivery			
past 12 months? yes a line pa	Month Day Year			
past 12 months? The birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown Output Division Divi	use contribute to the cause of death?			
Yes 2 A Was an autopsy.	No 3 Probably 4 Unknown			
24a Was an autopsy	24b. Were autopsy findings available			
The law require that been size to the law require that been size to law require the law require to law require to law require the law require to law require to law require the law require to law require the law require the law require the law require the law require the law require the law require the law requirements the	prior to completion of cause of death?			
The state of Death (Check only one) 25. Was case referred to medical examiner? Hospital: The state of Death (Check only one)	, , , , , , , , , , , , , , , , , , , ,			
The state of the s	ence 6 🗸 Other: Scene			
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28c. Injury at Work? 28d. Describe how injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28b. Time of Injury 2b. Time of Injury 2b. Time of Injury 2b. Time of Injury 2b. Time of Injury				
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Natural 5 Pending Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 2 Accident Investigation 3 V Suicide 6 Could not be	and Number or Rural Route Number, City			
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The state of the s	hway, Brooklyn, MD			
The first of the course of the	hway, Brooklyn, MD			
≥ 29b. Sign/ature and title of certifier 29c. License number 29d.	hway, Brooklyn, MD nd manner as started. ace, and due to the cause(s)			
29c. License number 29d. May 30. None and address of person who pe	hway, Brooklyn, MD nd manner as started. ace, and due to the cause(s) Date signed (Month, Day, Year)			
29c. License number 29d. May	hway, Brooklyn, MD nd manner as started. ace, and due to the cause(s) Date signed (Month, Day, Year)			

1 - State Registrar Certificate of Death Reg. No: 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** James Joseph Lishman 200b /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Samanta Baltimore Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security NV1264 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 ★M 2 ☐ F 91 Yrs. 187-05-5264-Pennsylvania Director December 31,1914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Mcdical Examinar must be notified at 1X Yes 2 No Director Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 3913 Bateman Avenue 21216 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 By Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Be Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Laborer Chemical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Joseph Lishman Vergie Bosche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is eny injury or other trau once. 11249 Country Club Road, New Market, Maryland 21774 Joseph S. Lishman (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial PK 05/16/06 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurd. List only one cause on each line. 8728 Liberty Road, Randallstown, Maryland 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SETSIS /Medical Due to (or as consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Heart Examine and I-transit The law requires that the death certificate be executed Acute Renal Due to (or as a consequence of) sicien a Records, P.O. Box 68760. Physician/Medical the attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an Arteral page cenificate 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ▼ No 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) zh D19584 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14.D Good Samaritan Hopital 5606 Lock Rev. Blod. Baltimore, MD 2123 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TEM#5, PER FH, G857, 7713/06, WS
State of Maryland / Department of Health and Mental Hygiene

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
Amend Trem 1 per doc 2006 6-0-06 vt
State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death Reg. No." 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month
MAY

4b. City, Town, or Location of Death Year 3:50Pm **Physician** Albin R. Leehowicz Albert R. Lechowicz 12 2006 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Arno1d Anne Arundel Chesapeake Future Care If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Funeral Months Days 1⊠M 2□ F Yrs. July 10, 1925 80 MD Director 219-18-9856 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at an ende. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21122 306 Delma Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 May Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2K No Specify: Saltimore, Maryland 21215-0020 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domino Sugar $1\dot{2}$ Machinist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Kazmiera Sieracki Albin Lechowicz 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 306 Delma Avenue; Pasadena, MD 21122 Mrs. Mary Ellen Lechowicz/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 17, Meadowridge Memorial 4 Donation 5 Other (Specify) Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licenses Moi357 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ADVANCED DEMENTIA Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 ☐ Yes 2 XNo 3 Probably 4 Unknown CORONARY DISEASE ARTERY Division of Vital Records. þ 24b. Were autopsy findings 24a. Was an autopsy performed? Be Completed available prior to completion of cause of deeth? 2 (No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 21X No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo 24 hours after death. Funeral Director: Al 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To tha h the 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature and title of certifier 2 May 12, 2006 monego MD D57531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Such 204 Millersville, no 2/108 , 8601 Veterans Hwy. Negi 32. Registrar's Signature 31. Date filed (Month, Day, Year) Joseph Registrar 6 2006

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma		partment o	nd Mental Hygiene Reg. No 2005 1537			
	Physic /Medi		1. Decedent's Name (First, Middle, Las	からのよう	16 40	2.		2. Date of De	eath Day 2006	3. Time of Death
	Examil Funeral		4a. Facility Name (If not institution, gives 5. Social Security Number 213-22-1761	Be Day	(In yrs. last birthday	PALTI () If Under 1 Y	, , ,	rs. 8. Date of Bir n. (Month, Da	th 9. B	re City irthplecs (State or Foreign Country)
	Director		Usual Residence of Decedent 10a. State 10b. County		79 Yrs.	Location		10-26-	-1926	MD 10d. Inside City Limits
	r 28a-f sh	Director	MD Anne Ar	unde1	Miller	sville	de		10g. Citizen of What (1 ☐ Yes 2€∑No
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Baltimore,	permit. Pages Department of H Important: If Its any Injury or of		Septimize Disposition 1 Burial 2 Cremation 3 4 Ronation 5 Other (Specify 21. Signs are of 3 mm. Sen ice License 1 1 1 1 1 1 1 1 1)	Maryland	Vets. (22. Name and A	Cem. 5-1	.6-2006 Singleton	Crownsvil n Funeral i	le, MD Home, PA
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O. Box 6	the death certific y the attending p ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. if yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify			23d. Date of de Month	olivery Day Year
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Division of Vital Records	The law ate has b page 2 s	Completed						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
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Ω̈́	Hospital or # 24 hours after Funeral Dire tely filled in b		4 Homicide determined 29a. Certifier 1 Certifying Phy	building, etc.	(Specify) my knowledge, dea	th occurred at th	e time, date and place	City or Tow	m, State)	e stated
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	le		30. Name and address of person who co	ompleted cause of dea	ath (ftem 23a) (Type	, Print)	IN PAVER	sivag c	AS CORV	QH OZI
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 200	32. Jegistrar		aradi)				51518

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П	Physici	an	Walter B. Moore				Month	Day Year	
E.	/Medic				# O' T		May 13,		12:45 P ^M
14	Examin	ıer	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		ר	4c. County of Death	
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	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
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	ath v		3414 Springdale Avenue		2121			USA	/
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<u>a</u>	should be nd Menta marked matic ev	٥	Joseph Moore			Fa	annie Watl	kins	
Maryland 21215-0036	and I		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Ru	rai Route Number, (City or Town, State, Zi	Code)
	s 1 and 2 should if Health and Mer Itam 27 is marke other traumatic		Barbara J. Moore/Wife	3414	Springda.	le Avenu	e Baltimon	re, MD 212	16
Baltimore,	f He f He itam othe		20a. Method of Disposition	20b. Place of Dispo				c. Location - City or T	
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			Edward A. Gregorchik					ce, MD 212	
			23a. Part1. Enter the disease or complications that caused to shock, or heart failure. List only one cause on each line	ne death. Do not ent	er the mode of dying	g, such as cardiad	or respiratory arres	ι,	Approximate Interval Between Onset and Death
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4	To the nospitule of Attention Privatcian: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director, it	Me	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (Month,	Day, Year)
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	6		30. Name and address of person who completed cause of dea		,				
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	Sta		31. Date liled (Month, Day, Year) 32. Registrar	's Signature					
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	Funeral			5. Sex 7	. Age (In yrs. last l		If Under Months		If Under 24		8. Date of I			9. Birth	place (State or Foreigntry)	nç
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination at any injury or other traumatic event, the Medical Examination at any once.		21. Signature of Funeral Service Li) 00											-
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		Decedent's Name (First, Middle, Last)			*		2. Date of Dea			3. Time of Death		
Physici		Bernice Martin					Month 04	20	06	18:10 M		
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Tow	m, or Loca	ation of Death		4c. County of Death				
	G1	Washington Adventist Hospital Takoma Park Montgomery										
Funeral Director		266 - 18 - 5651 1□ M 2⊠F 92	Yrs.			ours Min.	01 28	14	C	th Carolina		
pus ≱_		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	cation						10d. Inside City Limits		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Department of History and Mental Hydiene. Saportment of the Tile marked other then "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examplar must be notified at once.	٥	MD Prince Georges Belt								Maryes 2 No		
the N	Director	10e. Street and Number		10f. Zip Co	de			Og Citize	n of What C	country?		
with		10707 Green Ash Lane		2070				USA		ounty.		
eath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent	of Hispan	nic Origin? (Spe	cify Yes or No-	14	. Race - Am	erican Indian,		
lter d	ä	Armed Forces? 1 Never Married 2 Married 1 Yes 2 1 No	li li	Yes, specify	Cuban, M	lexican, Puerto F	Rican, etc.)		Black, Whi			
irs af	þ	3 XWidowed 4 ☐ Divorced	1	∏Yes 2√2	No Sp	pecify:		S	pecify: B1	ack		
2 hou				ient's Usual O				16b. Kind	of Business	s/Industry		
oic a	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	lite. L	kind of work di DO NOT use re	one during etired)	g most of workir	ng					
d with	Completed	9th.	Nui	rse LPN				Juni	or Vi	llage		
at Hyge	Bec	17. Father's Name (First, Middle, Last)			18.	Mother's Name	(First, Middle,	Maiden Su	ımame)			
Alenta Alenta Treed tice	ToE	Solomon Black			M	Mamie Gr	imes					
should have	-	19a. Informant's Name/Relationship (Type, Print)	b. Mailin	g Address (St	reet and N	Number or Rura	Route Number	r, City or T	own, State,	Zip Code)		
alth a		Gloria L. Shively/Daughter	1070	7 Green	n Ash	Lane,	Beltsvi	11e.	MO. 3	20705		
of He a	1	20a. Method of Disposition 20b. Place	of Dispo	sition (Name o	of place)	D	ate	20c. Loca	tion - City o	r Town, State		
Page entcent: F		LA Burial 2 Cremation 3 Hemoval from State				. 4-27-	-06	Suitl	and, M	D .		
mit.		21. Signature of Funeral Service Licensee				Facility MAr		Fune	eral H	lome		
Depa Impo		20 marshall	42	217 9th	. St	. N.W.	Washing	ton,	D.C.	20011		
	•	23a. Part. Enter the disease, or complications that caused the death. D								Approximate		
Dhysisian		shdčk, oř heart failure. List only one cause on each line. Immediate Cause (Final	ctor	, Digon						Interval Between Onset and Death		
Physician /Medical		disease or condition resulting in death) Coronary At Due to (or as a consequence)		DISEA	.50				· · · · · · · · · · · · · · · · · · ·			
Examiner		535 15 (5) 25 2 53/155435/15	0 017.									
	ē	Sequentially list conditions, If any leading to immediate Due to (or as a consequence	e of):									
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events										
be executed ician and burial-transit	Exa	resulting in death) Last C. Due to (or as a consequence	e of):									
ate be ex hysician the buria	dlcal	d										
ificate g phys	g											
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		Te				230	d. Date of de	alivery		
death d for	cla	in the past 12 months? 1 ☐ Yes 2 ☑ No		Ectopic pregn Other <i>(specif</i>					Month	Day Year		
that the de	hys	9 ☐ Unknown 9 ☐ Unknown										
signed (d be det	by P	Part II. Dther significant conditions contributing to death but not resulting	in the ur	nderlying caus	e given in	Part I.	23e. Did tol	bacco use	contribute (to the cause of death?		
quire on sig uld b							1 🗆 Yı	es 2 🗆 I	No 3□P	robably 4 Unknown		
s been si	Completed						24a. Was a		24b. Were a	utopsy findings available		
The lav	m _o						autops	med?	death?	completion of cause of s 2 \sumber No		
	O	25. Was case referred to medical			26	Place of Death	(Check only on		1 1 1 1 0	5 2 2 140		
the Hospital or Attending Physician: in 24 hours after death. the Funeral Director: After this certifici	OB	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatien	t 32 DOA	Other	I ☐ Nursing Hon			Other (Sp.	ecify)		
eral eral	n:T	27. Manner of Death 28a. Date of Injury 28b	. Time of		Injury at Work?		8d. Describe h			,		
E file in g	Certification:	1 Natural 5 Pending (Month, Day Fear) 2 Accident investigation	Injury		1 Tes	2 🗆 No						
Atte	110	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, of	fice	2	8f. Location (Si City or Town		Number or F	Rural Route Number,		
d in Direction	ert	4 Homicide building, etc. (Specify)		1			City of Town	i, State)				
spit hour ners y fille		29a. Certifier (X) Cartifying hysician: To the best of my knowled	ge death	occurred at the	ne time, da	ate and place, a	nd due to the c	ause(s) ar	nd manner a	s stated.		
n 24 n 24 ne Fu	edical	(Check only 2 Medical Examinar: On the basis of examination one)	ang/or inv	estigation, in i	ту оргног	n, death occurre	d at the time, d	ate and pl	ace, and du	e to the cause(s)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific compistely filled in by the funeral director.	Ž	29b. Signature and title of certifier		29c. Li	cense nur	mber	2			th, Day, Year)		
		Vital is the	7	4.	20	05		5	-//	1-2006		
/_		30. Name and address of person who completed cause of death (Item 23a	ı) (Type,	Print)						,		
5		Dr. Stephen Smith, M.D. 7600 Ca										
Sta	ate	31. Date filed (Month, Day, Year)	irro]	LI Ave.	Tak	oma PAr	k, MD.	2031/	·.			
Regist	rar	MAY 1 6 2006	ASS RES									

			For State Registrar	State o	f Maryla	•	artment of H		Mental Hy	giene Reg. No	006	15383	
			1. Decedent's Name (First, Middle	e, Last)					2. Date of De	_	Vaar	3. Time of Death	
300	Physici /Medic		Helen Rut	h McMah	an				Month	15, 2006 3:		3:00AM	
	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or	Location of Death	1	4c. Cou	inty of Death		
44			Cherrywood	Nursing	Home		Reist	erstown	1	Ва	1time	re	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth av. Year)	9. Birthp	lace (State or Foreign	
	Director		218-26-2363	1 □ M 2/□ /F	97	Yrs.	Wichins Days	Tiodis Wiii.	Sep. 3	80,190	8 Teni	nessee	
	p ,		Usual Residence of Decedent 10a. State 10b. County		100 0	it. Tour as la						Od Inside City Limits	
	show	_				ity, Town or Lo					'	0d. Inside City Limits XXYes 2 ☐ No	
	8a-f	cto	MD			altimo							
	or 2	D L	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	itry?	
	ath v	Funeral Director	4921 Gunth	ner Ave.				1206			S.A.		
	te m	une	11. Marital Status	Armed Fo	edent Ever in t proes?	J.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. F	Race - Americ Black, White,		
36	ours after death with the Maryla ral', or Items 23e or 28e-f shov Exerciner must be notified at	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve		1 □ Yes XXNo	Specify:		Spe	city: W	nite	
215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examinar must be notified at	D D	15. Deceden	Year or E	ales.	152 Door	ient's Usual Occup	ation		15h Kind o	f Business/Inc		
15.	_	Completed	(Specify only highes			(Give	kind of work done of NOT use retired	during most of wor	king	100. Kald 0	i ousiness/in	105079	
212	within lene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Sales Ci			Reta	ail Dr	116	
	be filed within 72 ho tal Hygiene. d other then "netun event, It's Medical		17. Father's Name (First, Middle,				34705 01	18. Mother's Nan	ne (First, Middle			49	
an	should be filed within and Mental Hygiene. marked other then matic event, the Mi	o Be	Robert	Dver				Corde	lia Gr	ev			
Maryland	s 1 and 2 should be filed v f Health and Mental Hygie Item 27 is marked other t other traumatic event, ID	2	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street				wn, State, Zip	Code)	
Ma	and 2 :salth ar n 27 is		Betty Lou Ree		hter	106	South R	itters	Lane. (Owings	Mi 11	s,MD21117	
ē,	item 27		20a. Method of Disposition	, , , , , , ,		Place of Dispo	sition (Name of		Date		on - City or To		
9			XXBurial 2 ☐ Cremation 4 ☐ Donation		State Da		natory or other place. Cemete	P 4 4	8/06	Balti	more.	MD	
Baltimore,	permit. Page Department of mportant: If any injury or once.		21. Signature of Fundral Stance		ı a							apel P.A.	
Ba	permit. Departmit. Importa eny inju			Ls,MD2111									
-57	¥		23a. Part1. Enter the disease, or	complications that	aused the dea	ith. Po not ent	er the mode of dyin	g, such as cardiac	or respiratory a	ırrest,	1	Approximate	
1	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on e	васл ште.	aun	limmu	muther			(Interval Between Onsevand Death	
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										
	Examiner		Sequentially list conditions b.										
4;		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	S .									
Ó	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to	(or as a conse	quence of):							
8760,	ysicia ysicia	dicai		d	_								
9	tifica g ph as th	ed		_									
Вох	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant		tcome of pregr		Ectopic pregnancy			23d.	Date of delive	nry	
	the att	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No		nant at time of		Other (specify)				Month	Day Year	
P.0	that the d ed by the detached	Å.	9 Unknown	9LI ONKI	OWN		- 0						
	The law requires that the death certifi ate has been signed by the attending I age 2 should be detached for use as	by F	Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use c		ne cause of death?	
rd	w require been si should b		[4	4/2744	row ic	m			10	Yes 2□No	o 3 ☐ Prob	abiy 4 donknown	
Vital Records,	aw re as be 2 sho	Completed		(•					24a. Was		b. Were auto	psy findings available appletion of cause of	
Ä	The Late ha	E							perfe	ormed?	death?		
ital		0	25. Was case referred to medical					26. Place of Dea		The same of the sa			
Y	× 5	To B	examiner? 1 Yes 2 No	Hospital: 1 🔲	Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5 Res	idence 6 🗆 0	Other (Specifi	()	
اه ر	ig Ph ter th neral		27. Manner of Death 1. ■ Natural 5 □ Pendin	28a. Date (Mon	of Injury	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe	how injury occ	curred		
Ö	andir sath. or; Al	atic	2 Accident investig	gation				Yes 2 □ No					
Division	r Atterder de l'recte	Certification:	3 ☐ Suicide 6 ☐ Could determ	lined 288. Place	of Injury - At I		eet, factory, office		28f. Location (City or To		ımber or Rura	l Route Number.	
	rital or rail												
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	ng Physicien: To the Exeminer: On the b	e best of my kn lasis of examin liner stated.	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	date and place	manner as si ce, and due to	ated. the cause(s)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Mec	29b. Signature and title of certifie				29c. License	e number		29d. Date sig	ned (Month,	Day, Year)	
	F 3 F 8		1	m	()		Di	7569					
,	5 7		30. Name and address of person	who completed as-	so of death (the	m 23a\ /Tunc	Print)						
0			So. Hamo and address priperson	1/2 1	lett L	em in	18	38 Cm	18ma	Tres	2 Reck	6 21208	
19.00	Sta	te	31. Date filed (Month, Day, Year)	2000	Registrar's Sign		rolls &	- 01		, , , ,			
	Regist		MAY 1 6	2000	11 Sand S	S. S. S. S. S. S. S. S. S. S. S. S. S. S							

			1 - For State Registrar	State of Man		artment of <i>rtificate of</i>		-	2006	15384
			Decedent's Name (First, Middle, Last)			rimoate of	Death	2. Date of De	Reg. No:- U U U	3. Time of Death
	Physic	ian	James Edwar		Sr			Month	Day Year	5:29 a м
	/Medi		4a. Facility Name (If not institution, give s		, 51.	4h City Town	or Location of Death	May 1	5 2006 4c. County of Death	
	Examir	ner	GREATER BALTIMORE		TNTER	TOWSON	or cocation of Death	'	BALTIMORE	
	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	45	place (State or Foreign
	Director		212-40-7484	(a	64 Yrs.	Months Days	Hours Min.	June 9	, 1941 Mars	intry) /land
	Р.		Usual Residence of Decedent						, = 0 12 1302	Lano
	arylar show	_	10a. State 10b. County MD Baltimo		c. City, Town or Lo					10d. Inside City Limits
	Ba-f	cto	134101111	ore	Owing	s Mills	· · · · · · · · · · · · · · · · · · ·			1 ☐ Yes XXNo
	or 2	Director	10e. Street and Number 9 Oakmere Rd.			10f. Zip Code			10g. Citizen of What Cou	intry?
5	hours after death with the Maryland hours after death with the Maryland tural', or items 23s or 28s-f show at Examinar must be notified at	Funeral (o daniele Ro.				1117		U.S.A	<u> </u>
177	er de	une		12. Was Decedent Eve Armed Forces?		Was Decedent of If Yes, specify Cui	Hispanic Origin? (Sp pan, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Amer Black, White	
7 %	rs aff	by F	1 ☐ Never Married, ※ Married 3 ☐ Widowed 4 ☐ Divorced	XXYes 2 ☐ No If Yes, Give Year or Dates:	1960- 1962	1□Yes XXNo	Specify:		Specify: T	Mite
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	72 hours after dea "natural", or items		15. Decedent's Educ			dent's Usual Occu	pation		16b. Kind of Business/li	
1		Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of won	king		ioudity
	led with lygiene her the	E	Elementary/Secondary (0-12)	College (1-401 5+)	D	esign D	raftsma	n	Manufactu	rina
7	be filed ital Hygi id other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	, Maiden Sumame)	
1 1 5	should be and Mental is marked o	2	George C. Ma	rtin			M	ary Hu	ngerford	
Harvey	2 she and is m		19a. Informant's Name/Relationship (Type						er, City or Town, State, Zi	
0/1	1 and Health Iom 27		Peggy Irene Mart						lls, MD 21	
7	Pages 1 nent of H int: If ite		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ R		20b. Place of Dispo cemetery, crei	nsition (Name of matory or other pla V1eW	ice)	Date	20c. Location - City or T	
<= !	. Pa tmen tant:		4 ☐ Donation 5 ☐ Other (Specify)		Memoria:	l Park	٠,٠	18/06	Sykesvil	
MAR	permit. Pages 1 and 2 should be filed within Depermit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other ther than eny injury or other fraumatic event. In the once.		21. Signature Theral Solvice Licens		22	2. Name and Addr	ess of FacilityEC	chardt	Funeral Ch	apel P.A.
	40200		Tuerrel /	mu					Owings Mil	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each line.	death. Do not ent	er the mode of dy	ng, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ailure					Onsot and Death
	Examiner		f	Due to (or as a co						
		ē	Sequentially list conditions, b	Diabetes Due to lor as a co		us				
	uted d ansit	m L	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		, ,					
c	be executed sicien and burial-transit	Examin	resulting in death) Last	Due to (or as a co	onsequence of):					
8760.	cate be executed physicien and the burial-transit	dlcai	L d	_						
9		Jed	IS CELLULE							
Вох	eath certific ettending p	an/N	200. Was decedent program	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnanc	v		23d. Date of deliv	өгу
G.	e dea he ett	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time 9☐ Unknown		Other (specify)	, 		Month	Day Year
٥	that the dended by the e	by Physician/Me	9 Unknown							
Division of Vital Records. P.O.	Physicien: The law requires that the death certificate has been signed by the ettending ral director, page 2 should be detached for use as	ž	Part II. Other significant conditions con	tributing to death but no	ot resulting in the ui	nderlying cause gr	ven in Part I.		obacco use contribute to t	/
orc	w require been si should b	Completed						101	/es 2 ☐ No 3 ☐ Prot	oably 4 ☑ Inknown
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<u></u>	: The cate he page							perfo	rmed? death?	2[] No
V It	stcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		. 04	26. Place of Deat			
ō	Phys this ral dir	<u>2</u>	1 Yes 2 No	1 Minpatient	2 ER/Outpatien	, 30 007			dence 6 Other (Special	(y)
u	5 9 9 E	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) Injury	Wo	rk? Yes 2∐No	28d. Describe r	now injury occurred	
isi	Attending of death.	flca	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, str.		1103 2	28f Location (S	Street and Number or Rura	al Route Number
Ö	after after Dire	Certification:	4 Homicide	building, etc. (S	pecify)	501, 120101 y ; 011100		City or Tow	vn, State)	ar rioble rebinder,
	spite nours nora rille	alc	29a. Certifier 1 Certifying Phys	ician: To the best of m	y knowledge, death	occurred at the ti	me, date and place.	and due to the	cause(s) and manner as s	tated.
	n 24 In Fu	Medical	one)	er: On the basis of exa and manner stated.	imination and/or inv	vestigation, in my	pinion, death occur	red at the time, o	date and place, and due to	the cause(s)
	To the Hospitel or Attendia within 24 hours after death. To the Funeral Director: A	ž	29b. Signature and title of certifier	C	140	29c. Licens			29d. Date signed (Month,	Day, Year)
	2		Renn K. Tho	no	MD	D60	0630		5/15/06	
_	U		30. Name and address of person who con			Print)	0			
			6565 N. Charles S	,		21204	Ken	14 Tho	Mas, MD.	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2001	32 Registrar's S		new			/	

				For State Registrar	State	of Maryla		artment of <i>rtificate o</i>	Health and N f Death		iene 0	16	15385
_		Physici /Medic		1. Decedent's Name (First, Mic Betty B. Mo		<u>.</u>				2. Date of Deat May 14,	th	Year	3. Time of Death 0636 M
		Examin		4a. Facility Name (If not institut			enter	1 1	, or Location of Death Air		4c. County Ha	of Death rford	d
	4	Funeral Director		5. Social Security Number 216-12-2519	6. Sex 1 M 2 F	7. Age (In y 85	rs. last birthday, Yrs.	If Under 1 Year Months Day		8. Date of Birth (Month, Day, Dec. 27	Year)	Coun	lace (State or Foreign try) yland
		and w		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c.	City, Town or L	ocation				1	Od. Inside City Limits
		Maryl 1 sho	ţō	Md. Ha	rford			Bel Ai	r				1 ☐ Yes 2X No
		h with the	al Director	10e. Street and Number 160 Royal 0	ak Drive,	Apt. G	3	10f. Zip Code	21015	1	0g. Citizen of V	/hat Coun	try?
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel" or Items 23e or 28e-f show any injury or other traumatic event. The Medical Example must be invilled at ance.	by Funeral	11. Marital Status 1 Never Married 2 M	arried Armed F	2∐ÎNo ive	1 U.S. 13.	Was Decedent of If Yes, specify Ci	of Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	Blac	- Americ k, White, o	
	Maryland 21215-0036	in 72 hours n "naturel" walcel Ex	Completed b	(Specify only high	ent's Education hest grade completed)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of work	king	16b. Kind of Bu		
	212	jene.	mo	Elementary/Secondary (0-12	?) College	(1-4or 5+)	optio				eye ex	amina	ation
	nd	al Hyg	Bec	17. Father's Name (First, Midd	le, Last)				18. Mother's Nam	ne (First, Middle, M	Maiden Sumam	θ)	
	ylaı	ould b Ments warked	10	Claude Hues					Mary				
	Mar	d 2 sh th and th and t7 is m traum		19a. Informant's Name/Relation Michele Mot		ar		_	et and Number or Rui Lane, Be1		-	State, Zip	Code)
	ē,	s 1 an f Heal ftem 2 other		20a. Method of Disposition		208	o. Place of Dispo	osition (Name of matory or other p		and the same of th	20c. Location ·	City or To	wn, State
	<u>E</u>	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other			-	Mem. G		/2006	Bel Air	, Md	•
	Baltimore,	permit. Departr Imports any inj		21. Signature of Funeral Servi	ce Licensee				ress of Facility k Funeral acPhail Ro				c.
	105/19			23a. Part. Enter the disease, shock, or heart failure. L	or complications that ist only one cause on	caused the de	eath. Do not en	ter the mode of d	lying, such as cardiac	or respiratory arre	est,		Approximate Interval Between
		Physician	1	Immediate Cause (Final disease or condition resulting in death)	_aA	cute	My	10 car	dial -	nfavo	tion		Onset and Death
36	ı	/Medical Examiner			Due to	(or as a cons	sequence of);	200					
9690			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(or as a cons	sequence of):					-	
)		ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last) c		^^						
0	8760,	cate be executed physician and the burial-transit	al E)	Toolking in doubly and	Due to	(or as a cons	sequence or):						
101	687		edical		0.	_							
11/5	O. Box	The law requires that the death certific te hes been signed by the attending p tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 ☐ F nant at time c	etal death 3	□Ectopic pregnar □ Other (specify)			23d. Date Mor	of delive	ry D <i>a</i> y Year
ج	rds, P	quires that in signed b uld be deta	by	Part II. Other significant cond	itions contributing to	death but not	resulting in the L	indertying cause	given in Part I.	23e. Did tob			e cause of death?
2	ecords	ne law requii hes been s ge 2 should	Completed	Congestive	2 Heart	Fai	lure			24a. Was a	n 24b. V	Vere autop	osy findings available appletion of cause of
at	α		Con	Essential	Hyper	lanci	D.h			perform	ned? d	eath? Yes	مسلمان 2
N	Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medi examiner? 1 Yes 2 No	Hospital)thos:	th (Check only one			
W	of	두 등 교	\vdash	27. Manner of Death	28a. Date		28b. Time o	IL SELDON	4 Nuising He	ome 5 Reside)
2	ion		atlo	Z - Moddont	stigation	illi, Day 16al) Injury		Yes 2 No				
116	Division	ospital or Attenhours after deathours after deathous uneral Olrector:	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete		e of Injury - A ling, etc. (Spe	t home, farm, st ecify)	reet, factory, offic	:e	28f. Location (Sti City or Town	reet and Numbe , State)	or Or Rural	Route Number,
1104		T 4 T 0	edical	29a. Certifier 1 ertif	ying Physician: To th ai Examiner: On the and mai	e best of my l basis of exam nner stated.	knowledge, deat ination and/or in	h occurred at the ivestigation, in my	time, date and place, y opinion, death occur	and due to the ca red at the time, da	ause(s) and mar ate and place, a	nner as stand due to	ated. the cause(s)
-		To the within 2 To the complet	W	29b. Signature and title of certi	nel M	100	- ND	29c. Lice	nse number	29	9d. Date signed	(Month, £	Day, Year)
to		5		30. Name and address of person	on who completed cau	ise of with (I	tem 23a) (Type,	Print)	E Law	Stront	W/W	201	loo.
E	100	Sta	10	31. Date filed (Month, Day, Ye.	ar) 32	Registrar's Sig	nature MD)	3 7000	Mary	and	2100	The state of the s
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Registr		MAY 1	6	latures.	13 As	now!		/			

06-03213 Mary Macrides

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cert	tificate of Death		Reg. No. 200	6 1538
Physicia	an/	1. Decedent's Name (First, Middle, l	ast)		Date of De Month	Day Year	3 Time of Death
ledical Exami	ner	Mary Macrides			May 12,	2006	1509 hrs
		4a. Facility Name (if not institution,		4b. City, Town, or l	ocation of Death	4c. County of Deat	
•	Щ	St. Joseph Medical Cen		Towson	Liste a distribution of the second		
Funeral			Sex 7. Age (In yrs. la	st birthday) If Under 1 Year Months Days	Hours Min	Birth(MM/DD/YYYY) 9. Bi Forei	an
Director	l	201-28-9025	M 2XF 78	Yrs.	Feb.	28, 1928 C	ountry) Greece
>-		Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Location			10d. Inside City Limits
w any							1 Yes 2 No
Aaryland 28a-f show 1 at once,	ĕ	Maryland Ha 10e. Street and Number	rhord	Bel Air 10f. Zip Code			
Mary 28a-	Director					10g. Citizen of What Cou	-
h the 3a or		577 Cressy Road		210	014	u. s. A	١.
h wit	Funeral	11. Marital Status1 Never Married 2 X Marr	12. Was Decedent Ever in U.S Armed Forces?		panic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.)	No- 14. Race - Amer White, etc.	rican Indian, Black,
or it	필		1 Yes 2 X No				1 . + -
s afte ral",	<u>a</u>		ed If Yes, Give Year or Dates:	1 Yes 2 X No			hite
hour natu	leted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	 Decedent's Usual Occupation during most of working life. 		16b. Kind of Business	industry
36 thin 72 than '	ble	Elementary/Secondary (0-12)	2 Years	Homemake	+ 2	Own t	tama
5-0036 iled within 7 Hygiene. I other than	dmo	17. Father's Name (First, Middle, La			8.Mother's Name (First, Middle		Tome
	Be C	Anastasios Kana	παλ		Demetra Pau	leros	
D 2121 should be fil and Mental I 7 is marked natic event,	P	19a. Informant's Name/Relationship		19b. Mailing Address (Street	and Number or Rural Route No		e, Zip Code)
e, MD 21 I and 2 should Health and Mer item 27 is man		Peter Macrides	(Spouse)	577 Cressy R	oad, Bel Air, I	Maryland 210	114
e, M I and 2 Health item 2		20a. Method of Disposition	20b. P	lace of Disposition (Name of centermatory or other place)		20c. Location - City or	
5 8 2 = 3 l		1 X Burial 2 Cremation	C +	Demetrios Cem	eteru 5/17/2006	Baltimore.	. Maruland
Baltimo permit. Pag Department Important: injury or ot	H	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic			of Facility Schimunek		
Balti permit. Departm Imports		Com. 3	-	9705 Belai	r Road, Nottin	aham. Marulo	and 21236
Physician		23a Part I. Enter the disease, or co					Approximate Interval
/Medical		failure. List only one cause or Immediate Cause (Final disease	a. Atherosclerotic Cardiova	ascular Disease			Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence of)				
	.	Sequentially list conditions,	b				
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):			
	E E	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of));			
ecuted and transi	I Exa		d				
al ex	edical	UNPENDED	AMENDED				
760, Teate be exect physician a	/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancy	_	23d. Date of deliver	ту
	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of dea	2 Fetal death 3	Ectopic pregnancy	Month	Day Year
Box 68': death certifi he attending	sician	1 Yes 2 No 9 V Unkno		5 Other (Specify)			
J. B. the de cy the	Phy	Part II. Other significant condition	1 —	sulting in the underlying cause g	iven in Part I. 23e Did	tobacco use contribute to	the cause of death?
ires that the signed by I be detached	þ				1 —	es 2 No 3 Pro	bably 4 🗸 Unknown
rds, require been signould b	Completed					s an 24b. Were a	utopsy findings available
Records, The law requir ficate has been s	l de					opsy prior to formed? death?	completion of cause of
Rec The icate page	5				1 Yes	2 No 1 ✔ Y	es 2 No
Vital Rec ysician: The his certificate director, page	Be (25. Was case referred to medical examiner?	Hospital: 4 Imposiont 2 A		of Death (Check only one)		
Vid Thysic This	힏	1 Yes 2 No	Impatient 2	Erocupation o box	Other Nursing Home 5	Residence 6 Othe	er:
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. The Funeral Infector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		27. Manner of Death 1 ✓ Natural 5 Pendin	(Month, Day, Year)	· · ·	y at Work? 28d. Describe	e how injury occurred	
Sior Attend r death ector: by the	atio	2 Accident S Pendin	gation				
ivis lor A after Dire	ertification:	3 Suicide 6 Could determ	not be	me, farm, street, factory, office b	uilding, etc. 28f. Location or Town,	(Street and Number or R , State)	ural Route Number, City
Divi	ပ	4 Homicide	(openity)				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical	Check only 1 Certifying Phy	sician: To the best of my knowledg ner:On the basis of examınation ar	e, death occurred at the time, da nd/or investigation, in my opinion.	te and place, and due to the ca death occurred at the time, dat	use(s) and manner as sta te and place, and due to the	rted ne cause(s)
To tl withi To tl	led	29b. Signature and title of certifier	and manner stated	29c. License		29d. Date signed (Mo	
	Σ	1 0 H 1 0	LLPI ODA	A O.C.M		May 14, 2006	mui, Day, I Gai)
1		awe	ITULLA		VI. C.	Way 14, 2000	
10	J. ()	30. Name and address of person w		^{23a)} 111 Penn Street, Baltimo	ore MD 21201		
			32. Registrar's Signatur		JIO, IVID E IZU I		
S Regis	tate	MAY 1 6		1 Source			

	1 - For State Registrar	State of Marylan		t of Health and N e <i>of Death</i>		ene 2006	15387
Physician /Medical	1. Decedent's Name (First, Middle, Las	Gure			2. Date of Death Month	Day 2006	
Examiner	4a. Facility Name (If not institution, give University of Mary		nter Ba	Town, or Location of Death Ithmore		4c. County of Death N/A	
Funeral Director	389-54-1093	7. Age (<i>in yrs. i</i>	ast birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y) Jan. 3,	9. Birth	nplace (State or Foreign unity) USCONSÍN
death with the Maryland ms 23e or 28e-f show rmust be notified at	Usual Residence of Decedent 10a. State 10b. County MaryLand Bal 10e. Street and Number	10c. City	, Town or Location Parkvi		100	Cision of Wh	10d. Inside City Limits 1 ☐ Yes 2 No
ath with the same same same same same same same sam	22 Perry Woods Co		10f. Zip	21234		G. Citizen of What Cou	Α.
036 ours after death vest; or thems 23s Examinating mutt. by Funeral	11. Marital Status 1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		ent of Hispanic Origin? (Sp rfy Cuban, Mexican, Puerto Marian, Mexican, Puerto Marian, Mexican, Puerto Marian, Mexican,	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23e or 28a-1 ehow any njury or other traumatic event, the Medical Evantinar must be notified at once. To Be Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			I Occupation k done during most of work e retired) Strator	Bo	ib. Kind of Business/Ir altimore C Urks & Rec	ounty Dept.
Maryland 2 nd 2 should be filed the and Mental Hygi 27 is marked other rtraumatic event, To Be Co	17. Father's Name (First, Middle, Last) James McGuire	1 Tewes	Nanzero	18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)	temotor
Mary and 2 sho alth and 1 127 is me or traums	19a. Informant's Name/Relationship (7) Katie McGuire (Wi	,, ,	1	(Street and Number or Ru Joods Cowit,			
Baltimore, semit. Pages 1 ar Jopes 1 ar Jopes 1 ar Jopes 1 ar Jopes 1 ar Mandriant: If Itam my njury or other ance.	20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	lace of Disposition (Nameratory or of Wiew Crematory or of Wiew Cremat	te of her place)	Date 20 1/2006 B	c. Location - City or T Baltimore,	own, State Maryland
Balt permit. Deperti Import any nj	21. Signature of Funeral Services icen.			d Address of Facility Sch Lair Road, I			
Physician /Medical	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ock	e of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
Examiner light	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, ,	o liver dis	ease			8 years
68760, filtrate be executed a physician and as the burial-transit edical Examiner	that initiated events resulting in death) Last	c. U Due to (or as a consequence)	ence of):				20 years
Box (death certification) death certification death certification death certification death deat	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pre			23d. Date of deliv Month	rery Day Year
	Part II. Other significant conditions co	ntributing to death but not resu	ilting in the underlying ca	iuse given in Part I.	23e. Did tobac	cco use contribute to t	the cause of death?
- () > Q to W					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 No
hysic this can all direct	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		ER/Outpatient 3 DO.	Other: 4 Nursing Ho	th Check only one ome 5 Residence 28d. Describe how	e 6 Other (Special	fy)
Division of teal or Attending P rs after death. al Director: After led in by the funers Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined	(Month, Day Year)	me, farm, street, factory	Bc. Injury at Work? 1 Yes 2 No		et and Number or Run	al Route Number,
Hospi 4 hour Funer iely fill	29a. Certifier (Check only one)	sician: To the best of my know	wledge, death occurred a now or investigation.	at the time, date and place, in my opinion, death occur	and due to the caus	se(s) and manner as s	itated. o the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier	and manner stated.		License number		Date signed (Month,	
	30. Name and address of person who o	ompleted cause of death (Item		64246	N.	lay 15,	2006
State	Kimberly M Lun 31. Date filed (Morth, Day, Year) MAY 1 6 201	PKINS MD 22 34 Registrar's Signat	S Green	e St Baltin	nore MD		
Registrar	MINITOSO	The state of	8				

			For State Registrar	State of M	aryland .		artment of tificate of		Mental Hyg	iene _{eg. No.} 0	06	15388
	Physici		1. Decedent's Name (First, Middle, IClara V. M						2. Date of Deal Month May 1	Day	Year 6	3. Time of Death 8:35a _M
	/Medical Examiner 4a. Facility Name (If not institution, give street and number) Gilchrist Center 5. Social Security Number 6. Sex 7. Age (In yrs. last b)						4b. City, Town	or Location of Dea	th	4c. County Balt		:e
4.	Funeral Director		216-36-3692	. Sex 7. Ag 1 ☐ M 2 🔀 F	ge (In yrs. last 66	t birthday) Yrs.	If Under 1 Year Months Day			, 1940	9. Birthp Coun West	place (State or Foreign http:// Virginia
	Aaryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	10c. City, T	own or Lo					1	I Od. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the P 23e or 28e-	il Director	10e. Street and Number 707 Norris L	ane			10f. Zip Code	221	1	10g. Citizen of What Country?		
036	urs after death al', or iteme 2 Exerciner mu	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1	?	l'	Vas Decedent of Yes, specify Cu	Hispanic Origin? (Sban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	14. Rad Blad	ce Americ ck, White, v: Whi	etc.
21215-0036	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other then. "natural", or Items 23e or 28e-f show say injury or other treumatic event, the Medical Examinant must be notified at an ance.	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 1 2 th	Education grade completed) College (1-4or		(Give life. L	lent's Usual Occ kind of work don OO NOT use reti maker	e during most of wo	orking	16b. Kind of B		ŕ
Maryland	uld be ille Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, La Dwight Cha	^{st)} pman					me (First, Middle, F Gillspi		ne)	
	ind 2 sho alth and h 127 ie ma er treums		19a. Informant's Name/Relationship Kenneth Mino:				•		ural Route Number Baltimor			
Baltimore,	Pages 1 anneal of He		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Bay	a of Diago	sition (Name of natory or other p Crema			Balti	City or To	own, State
Balti	permit. Depertr Imports eny inje		21. Signature of Funeral Service Lic	ensee Ons	re Ol		Name and Add	3 (00 Mace al Home			
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List of Immediate Cause (Final disease or condition	my fications that cause by one cause on each i	ine. (on ot enter		ying, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death) Sequentially list conditions,	b	a consequen							
8760,	icate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, it any, beauty to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequen							
O. Box 6	The law requires that the death certificate ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	ath 3	Ectopic pregnar Other (specify)	су		1	te of delive	ary Day Year
٥	w requires that been signed b should be deta	ρ	Part fl. Other significant conditions	s contributing to death b	out not resultin	ng in the ur	nderlying cause (given in Part f.	23e. Did tot			ne cause of death?
Vital Records,		Completed							24a. Was a autops perforn 1 ☐ Yes 2	y ned?	Were autop prior to cor death? 1 Yes	psy findings available mpletion of cause of 2 No
Division of Vita	Attending Phy r death. ector: After this by the funeral d	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigal 2 Accident G Could not determine	be 28e. Place of In	ay Year) 28	Outpatien b. Time of Injury a, farm, stre	28c. In W	ther: 4 Nursing I ury at ork? Yes 2 No	ath (Check only on Home 5 Reside 28d. Describe ho	ence 6 oth	red	
Ω	To the Hospital or within 24 hours after To the Funerel Dir completely filled in it	edical Cer	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of my knowle	idge, death	occurred at the	time, date and plac	e, and due to the ca	ause(s) and ma	inner as st	tated.
	To the Hospital within 24 hours To the Funerel completely filled	Med	29b. Signarure and title of certifier	and manner st	ated.		γ	nse number		9d. Date signe	d (Month, i	
1	00		30. Name and address of person when AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	o completed cause of a		За) (Туре,		A LANCE CONTRACTOR	MD ZI	204		
1	Sta Registi		31. Date filed (Month, Day, Year)		rar's Signature							

06-03247 Henry A Mast

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		Registrar	te of Death	7.5	No 200	6 1538				
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Henry Ambrose Mast		2. Date of Death Month May 14, 20	Day Year 06	3. Time of Death 0330 hrs				
		Facility Name (if not institution, give street and number) Franklin Sgare hospital	4b. City, Town, or Location of De Rosedale		4c. County of Death Baltimore Cou					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or				
Director		$219-30-3127$ $ X_{M} _{2}$ $ X_{F} _{2}$	Yrs. Months Days Hours	Min. Sept.1	8,1934 Col	Maryland				
any		Usual Residence of Decedent 10a. State								
Aaryland 28a-f show 1 at once.	tor	MD Baltimore I		ltimore						
ith the Maryland 23a or 28a-f sho notified at once.	Director	95 Ginwood Lane	10f. Zip Code 21221	100	g. Citizen of What Coun USA	try?				
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- rto Rican, etc.)	14. Race - Americ White, etc	an Indian, Black, nite				
ırs after tural", ıminer		3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. D	1 Yes 2 X No specify: ecedent's Usual Occupation (Give kind	of work done	Specify: 16b. Kind of Business/Ir	ndustry				
E1 3 =	oletec		uring most of working life. DO NOT use ${ t Driver}$	etired)	Alliance	· ·				
5-0036 led within 72 hours Hygiene. other than "natur	Completed by	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma						
	Be	Samuel Mast		ace Bayn						
AD 2 shc 27 is mati	T _o	19a. Informant's Name/Relationship (Type, Print) Dora Noreen Judy-Daughter 45	Mailing Address (Street and Number of 8 Mary Kay Cour	rt-Linthi	er, City or Town, State, cum, Maryla i	nd 21090				
of H		1 VPuriol 2 Comption 3 Demonstrate Cremator	Disposition (Name of cemetery, y or other place) Sins Of Faith Cemetery		20c. Location - City or Rosedale,					
Baltimo permit. Pag Department Important:		27 Ignature of Funeral Service Licensee	22. Name and Address of Facility EV 8800 Harford	/ANS CHA	PEL OF ME kville.MD	MORIES 21234				
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Due to (or as a consequence of):	Cardiovascular Disease			Death				
.*	i.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	Examiner	Colsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
executed an and al - transit		d		12						
e be buri	/Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery					
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pred Other (Specify)	nancy	Month Di	ay Year				
D. BC It the des by the a		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?				
cords, P.O. law requires that the has been signed by 2 should be detach	ed by			1 Yes	2 No 3 Proba	ably 4 🗹 Unknown				
cord law req has bee 2 shoul	Completed			24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of				
Vital Records sysician: The law requ his certificate has been director, page 2 should		25. Was case referred to medical	26.Place of Death (Cher	1 ✓ Yes 2		2 No				
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Out	Othor		esidence 6 Other:					
Division of Vital Records, rat or Attending Physician: The law require rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be		27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Ti	me of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred					
ViSic or Atter fter dea Director in by th	Certification:	2 Accident Investigation	n, street, factory, office building, etc.		eet and Number or Rura	al Route Number, City				
Opidal ospital obours a nineral I		4 Homicide determined (Specify)		or Town, Sta						
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: /	Medical	Check only one) 2 Medical Examiner: On the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invalid								
£ ≥ £ 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)				
(X)		30. Name and address of person who completed cause of death (Iten 23a)	O.C.M.E.		May 14, 2006					
5		Carol Allan, MD Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 212	201						
St Regis	ate trar	31. Date filed (Month When Year) 6 2006 32. Red strar's Signature	Goods							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 2. Date of Death Month 3,2006 cility Name (If not institution, give street and number) 4b. City, Town, or Location of Death tospice OWSON saltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs., last birthday) Days Hours 1 ☐ M 2 🗙 F 64 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits Bal 1 Yes 2 Yo timore a 10g. Citizen of What Country? 10f. Zip Code 21133 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Blac Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT us retired) (Specify only highest grade completed) Co ege (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Lasi 18. Mother's Nam (First, Middle, yward 19b. Mailing Address (Streen ad N 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ R
4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenshe town, MD 23a. Part1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Breast (ances months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its asset of the cause). Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f shov

Itema 23a

permit. Pages 1 and 2 should be filed within 72 hours after Copertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0036

90

the Medical Examiner must be notified at

Director

Funerai

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Completed

Be

Examine ed by the attending physician and detached for use as the burial-transit Physician/Medical certificate has been signed by i rector, page 2 should be detact þ Completed After this certific funeral director, Be Certification: To

The law requires that the death certificate be executed

Division of Vital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner?

2 No

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

Was an autopsy performed?
Yes 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 ER/Outpatient 3 DOA

28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

1 Tes

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

28b. Time of Injury 28c, Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0051926 29d. Date signed (Month, Day, Year) 13,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Me Gordon MO

6601 N. CHARLES STREET TOWSON. 21204

State Registrar

within 24 hours after death To the Funeral Director: , completely filled in by the f

Medicai

31. Date filed (Month, Day, Year) 6 2006



Gorse

			1 - For State Registrar	State of Maryland		artment of laterate of		and M		giene Reg. No.	06	15391
	Physici /Medi	cal	Decedent's Name (First, Middle, La		M	RINE	R		2. Date of De Month	Day 14	Year 2006	
	Examir Funeral Director	ner	HARBOR HOSPI 5. Social Security Number 6. S	TAL CENTE		4b. City, Town, BAL If Under 1 Year Months Days	TIMC If Under	RE	8. Date of Bir (Month, Da 3-12-	Ba1		e City place (State or Foreign intry)
	h the Maryland or 28e-f show or notified at	Director	Usual Residence of Decedent		Town or Lo					10g. Citizen o		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
980	d within 72 hours after death with the Maryland jiene. Ir than "naturel", or Items 23e or 28e-f show the Medical Examinar must be trofilled at	by Funerai	108 3rd Ave SW 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	21061 Was Decedent of f Yes, specify Cut		gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)	В	· A · ace · Ameri lack, White	etc.
121215-0036	I within liene. r than	Completed	15. Decedent's E. (Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire memaker	during mosi			16b. Kind of	Home	ndustry
Maryland	Mental Mental arked c	To Be	17. Father's Name (First, Middle, Last, Albert H. Dogge 19a. Informant's Name/Relationship (19b Mailin	g Address (Stree	Irma	Wade				n Code)
	s 1 and 2 sho f Health and item 27 is my other traum		Mrs. Pamela Boyd 20a. Method of Disposition	/ daughter	418	Lincoln sition (Name of natory or other pla	Ave S	W; G]			2106	L
Baltimore,	permit, Pages i Department of H Importent: If ite any injury or ot once.		1 ⊠ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specification of the control of the contr	I I GITTO VAL ITOLIT STATE	Have:	n Mem. P Name and Address Second	ark 5	y Sir	ngleton		a1 Hor	ne, PA
	Pnysician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. one cause on each line. INFECT		er the mode of dyi	4 =		-	rest,		Approximate Interval Between Onset and Death
8760,	be executed cian and burial-transit	Jicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d	FA	ILURE						2 YEARS
P.O. Box 6	the death certific y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dear 9 Unknown	leath 3 🗌	Ectopic pregnanc Other (specify)	у				ate of deliver	ery Day Year
	sign sign d be	by	Part II. Other significant conditions of	ontributing to death but not result		derlying cause gr	-		23e. Did to		_	he cause of death?
al Reco	The ate ha	Completed		NTION					24a. Was autop perfor	sy	Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of 2□ No
Division of Vital Records,	To the Hospitel or Attending Physicien: Th within 24 hours attendeath. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 Ho 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	P/Outpatient 8b. Time of Injury	28c. Inju	ier: 4 □ Nui	rsing Hom	(Check only one 5 ☐ Reside 8d. Describe h	lence 6 🗆 Ot		y)
Divis	= = ± ± = =	Certification	3 Suicide 6 Could not be determined	building, etc. (Specify)					City or Tow	n, State)		il Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Director Completely filled in I	Medicai	29a. Certifier (Chack only one) 1 ☑ Certifying Ph 2 ☐ Medical Exan	ysician: To the best of my knowl liner: On the basis of examinatio and manner stated.	edge, death in and/or inv	occurred at the tilestigation, in my c	pinion, deat	d place, ar h occurre	d at the time, o	date and place	, and due to	the cause(s)
)	7 × × ×		Idalil.	mD	12a) /Tu	RE	S O	21		29d. Date sign		2006
П	Sta	te	30. Name and address of person who a RAG HAD JALI 31. Date filed (Month, Day, Year)	L 3001 So 32. Registrar's Signatur	UTH F	JANOVEN	e str	REET,	BALTI	MORE, (np a	11225
	Registr	100	MAY 1 6 2			met						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. **Physician** /Medical Examiner

		State o	f Marylan	•	artment of <i>rtificate of</i>			, ,	jiene _{eg. No.} 2 (106	153
1. Decedent's Neme	(First, Middle, La	ist)						2. Date of Dee	th		3. Time of Dea
Mac	ton J		M	10C	llom, s	r.		Month	Dey /2	2006	4:5
4e. Fecility Neme (If		e street end nu			,	4b. City, To	own, or Loca	ation of Death		y of Deeth	
McCready	Hospita	1			1	Cris	field		Some	rset	
5. Sociel Security No		Sex	7. Age (In yrs.	ast birthday)	If Under 1 Yee Months Devs		24 Hrs. 8	B. Dete of Birth	Vearl	9. Birthpla	ce (State or For
216-36-0	395	1⊠ M 2□ F	65	Yrs.	WOTHIS Deys	Hours	WIIII.	July 19	9, 1940	MD	''
Usual Residence of 10a. Stete	Decedent 10b. County		10- Cit	. T						140	
			Too. On	, Town or Lo	ocation					100	I. Inside City Lir 1 ☐ Yes 2 🔯
MD	Somerse	t	M.	arion	Station						
10e. Street end Num					10f. Zip Code	_		1	0g. Citizen of		yr.
6900 Cha	rles Can			C 12	2183		ining (Casa	Yes or No	U.S.A	ce - Americar	Indian
 Marital Status Never Marrie 	ad 2 Married	Armed Fo		3. 13.	Was Decedent of If Yes, specify Cul	an, Mexica	n, Puerto Ri	can, etc.)		ick, White, et	
3 ☐ Widowed		If Yes, Gi	ve		1 □ Yes 2 🖾 No	Specify.	:		Specia	_{fy:} wh:	ite
	15. Decedent's E	1		16a. Dece	dent's Usual Occu	pation			16b. Kind of E	Business/Indu	strv
(Speci	fy only highest gr	ade completed)	4.4 5.\	(Give life.	kind of work done DO NOT use retire	during mos	st of working	,			J,
Elementary/Secor	loary (0-12)	College (1-40r 5+)	Pain	ter				Pai	nting	
17. Father's Name (First, Middle, Last)				18. Moth	er's Name (First, Middle, I			
Morton J	. McCull	om, Sr.				Bes	ssie N	1. Pott	er		
19a. Informant's Na	me/Relationship (Type, Print)		19b. Maili	ng Address (Stree	t and Numb	er or Rural i	Route Number	, City or Town	, State, Zip C	ode)
Mrs. Jane	et L. Bo	ecker /	sister	1152	5 Reed C	ircle	Ride	gelv. M	D 2166	0	
20a. Method of Disp	osition		20b. P	lace of Dispo	osition (Name of matory or other pla		,		20c. Location		n, State
	☐Cremation 3.☐ 5 ☐Other (Speci		State		n Memori		rk Ma	19 16,	Glen B	urnie	MD
21. Signature	2 / /		- 100		2. Name and Addr			2006 ngleton			
V	11		190	11 (11)	Second						C, 111
23a. Part 1. Enter 16 shock, or hear	M		1 1 1 11				-				pproximate
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.											
Ceuse (Disease or in that initiated events resulting in deeth) L.		c	Due to (or	as a conseq	uence of):						
		u									
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								24a. Wes en		availa	autopsy finding able prior to eletion of cause ath?
								1 □ Ye	s 2 No	1 🗆 🗅	res 2□ No
25. Was case referre	ed to medical					26. Place	e of Death	Check only on			
examiner? 1 ☐ Yes 2 🗖 N	No	Hospital: 1	Inpatient 2 🗆 I	ER/Outpatier	nt 3 DOA	har:		5 ☐ Reside	7	ner (Specify)	
27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 ☐ Pending investigatio	28e. Date (Mon		28b. Time of Injury	· Wo		28 No	d. Describe ho	w injury occur	rred	
4 ☐ Homicide	determined	28e. Place buildi	ng, etc. (Specify)	eet, factory, office			f. Location (St. City or Town	, State)		
29a. Certifier (Check only gone) 29b. Signature and t	1 Certifying Ph 2 Medical Exer	niner: On the ba	asis of examinat	ion and/or in	vestigation, in my	opinion, dea	th occurred	at the time, da	ate and place,	and due to th	e cause(s)
30. Name and addre	LCU ss of person who	completed caus	se or death (Item	23a) (Type	29c. Licen D0 5 Print) 1/04 S (3. 1 / 5)	602	25	way T	WY /	5, 2	006
STENER	HAM	ETTE	Mel)	Salis	bur	4,1	ND	7180	1	
Date filed (Month	AAY 1 6 2	2006	sistrar's Signat	ure S.	back		•				

within 24 hours effer death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Replacement

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib

			For Amend item#21	, petate, of Ma	nyland/Hepa		lealth and N	•			-15	39:
	Dhysiei		1. Decedent's Name (First, Middle, La	st)				2. Date of De	Dav	Year	3. Time of	Death
	Physici /Medio		Shawn Michael Morr					May 9, 2	2006		2115	M
A	Examir		4a. Facility Name (If not institution, give			• •	Location of Death			ity of Death		
-			John Hopkins Hospita 5. Social Security Number 6. S		(In yrs. last birthday)	Baltimore	If Under 24 Hrs.	8. Date of Bi		ore Cit		r Fomian
100	Funeral Director			M 2□F 23	Yrs.	Months Days	Hours Min.	Feb. 25	ay, Year)	MD	lace (State o.	- Toraign
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside Cit	ty Limits
	death with the Maryland rms 23a or 28a-f show r must be notified at	Director	MD Anne Aruno 10e. Street and Number	lel	Severna Park	10f. Zip Code			10g. Citizen o	f What Coun	1 🗀 Yes	XX No
	with with	ă	136 Inverness Road			21146			U.S.A.	T WINZE COUN	ity:	
	death ms 2;	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No		ace - Americ		
980	hours after furel, or ite	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 PN If Yes, Give Year or Dates:	0	fYes, specify Cuba 1□Yes 2 XX No	in, Mexican, Puerto Specify:	Rican, etc.)		ack, White, white, white		
Maryland 21215-0036	in 72	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	fucation ide completed) College (1-4or 5-	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work f)	king	16b. Kind of	Business/Inc	lustry	
21	filed withi Hygiene. other than	E	12			loyed			Une	employe	1	
land	od at b ♥	To Be (Father's Name (First, Middle, Last, Jeff McGeehan 				18. Mother's Nam Karen Le		, Maiden Suma	ame)		
Mary	and is m		19a. Informant's Name/Relationship (Mrs. Karen Morris / Mo			g Address (Street	and Number or Rui	al Route Numb		n, State, Zip	Code)	
Baltimore,	permit. Pages 1 and 2 Depertment of Health Important: if item 27 eny injury or other tra ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crer	natory or other plac	e)	Date	20c. Location			
tim	t. Pa rtmen rtant: njury		4 Donation 5 Other (Specif	-	Chesapeake			4, 2006				
Bal	Depertment of the control of the con		21. Signature of Funeral Service Licer Jared T. Skarda			Second Aver		ingleton Burnie,		Home, P.	.A.	
,092	Physician /Medical Examiner Assicion and Physicion and Phy	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to manadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a	ions of aceta a consequence of): a consequence of):	minophen to	oxicity				Onset and C	Jeatn
P.O. Box 68	The law requires that the death certificate be exite has been signed by the attending physicien age 2 should be detached for use as the buria	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 19 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				eate of delive	,	'ear
	w requires that been signed t should be det	d by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.		obacco use co Yes 2∭X No		e cause of de abiy 4 🗆 U	
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ta	sician: Th certificete irector, pag	0	25. Was case referred to medical				26. Place of Deat	1X Yes		1A1 Yes	2U No	
ίV	d is	ToB	examiner? 1- MYes 2 □ No	Hospital: 1 🛣 Inpatier	nt 2 ER/Outpatien	t 3 DOA Othe		15		ther (Specify)	
0	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day	y 28b. Time of Injury	28c. Injury Work	at	28d. Describe	how injury occu	ırred		
Sio	death, ctor: After y the funer	atic	2 ☐ Accident investigation	Fnd 5/5/200				Subject i				
Division of	saffor Att saffor do al Direct	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju building, etc Home	ry · At home, farm, str . (Specify)	eet, factory, office		28f. Location (City or To Severna	Street and Num wn, State) 138 Park, MD	B Iverne	Route Numbers Rd.	er,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one)	ysician: To the best on niner: On the basis of and manner state	examination and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the	cause(s) and n	nanner as sta , and due to	ated. the cause(s)	1
	within To th	Me	29b. Signature and title of certifier	n		29c. License	number		29d. Date sign	ed (Month, L	Day, Year)	
			· ///	m RIDE	reln	O.C.M.	E		May 11, 2	2006		
-			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,		116		- /	-		
			Laron Locke, MD 111	Penn Street,	Baltimore, M	D 21201						
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 5 21	32 Hegistra	r's Signature	role)						

DHMH 17 Rev 1/2001

Matthew J Nazelrod

Please Type or Print in Black Indelible Ink

attnew J. Naze		চার 1- For State Registrar	te of Maryland /		tificate of L		iu ivientai r		eg. No. 200	16 1539
Physicia Medical Examin	ın/	Decedent's Name (First, Middle, Matthew	J. Nazelro	od				2. Date of Deat Month May 13, 20	th	3. Time of Death 0808 hrs
		4a. Facility Name (if not institution, John Hopkins Bayview		_		City, Town, o	r Location of Dea		4c. County of Deat	
Funeral		5. Social Security Number 6	S. Sex 7. Age		st birthday)	If Under 1 Year		rs. 8. Date of Bir	th (MM/DD/YYYY) 9. Bi	rthplace (State or
Director		Usual Residence of Decedent	1 X M 2 F	19	IIS.			sept.	. 23, 1900 _{Cc}	ountry) PID
d now any		10a. State 10b. County MD Balti	1		Town or Location					10d. Inside City Limits 1 Yes 2 No
with the Maryiand ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 1509 Leslie	Poad		1	0f. Zip Code 21222)	10	Og. Citizen of What Cou	ntry?
with the ns 23a o	_	11. Marital Status	12. Was Decedent E	Ever in U.S		ecedent of Hi	spanic Origin? (Specify Yes or No	- 14. Race - Amer	ican Indian, Black,
ter death ", or iter	Funeral	1 X Never Married 2 Mar 3 Widowed 4 Divor	1 Yes 2 2	X No		specify Cuba	n, Mexican, Puer	to Rican, etc.)	White, etc.	ite
hours af 'natural Examin	ted by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	I or Dates:		16a. Decedent's	Usual Occupa			16b. Kind of Business/	Industry
0036 vithin 72 ene er than "	Completed	12th		,	Un-em	ployed			none	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, L Robert Naze)						ne (First, Middle, N Simmers	,	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationshi Dawn Lilly	p(Type, Print) /mother						nber, City or Town, State MD 2122	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene Important: If item 27 is marked other than "nat nigury or other traumatic event, the Medical Exa		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from State	20b. P	lace of Disposition rematory or other yview	n (Name of ce place)	metery,	Date 5/18/06	20c. Location - City or Baltimo:	
Baltimore, permit Pages I at Department of Hee Important: If ite		4 Donation 5 Other Spe 21. Signature of Funeral Service L		1					AVA Ba	1+0 MD
മ ≊ ≗ ≞ ≘് Physician		23a. Part I. Enter the disease, or c	inplications that caused t	he death.	///				Ave Ba of Esse	Approximate Interval
/Medical Examiner		failure. List only one cause o Immediate Cause (Final disease or condition resulting in death)	n each line. a. Narcotic in Due to (or as a consec							Between Onset and Death
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'60, ate be ex ohysician		X UNPENDED	23c. If yes, outcom			,27,28a-	r,penul,go	355,5/18/06	23d. Date of deliver	y
68 certifi nding ise as t	Physician/	23b. Was decedent pregnant in the past 12 months?	4 Pregnant at t	ime of dea	oth	death 3 (Specify)	Ectopic preg	nancy	Month	Day Ye ar
O. Bo at the dea by the a		Part II. Other significant condition	3 Olikilowii	but not re	sulting in the und	erlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
IS, P.O. quires that the en signed by tailed be detached.	ted by	Cocaine use						1 Yes	No 3 Pro	bably 4 Unknown
Division of Vital Records, P.O. Box rat or Attending Physician: The law requires that the death rs after death. al Director: After this certificate has been signed by the atterled in by the funeral director, page 2 should be detached for u.	Completed					 		autop	sy prior to med? death?	completion of cause of
tal R cian: T certifica ector, pa	Be	25. Was case referred to medical examiner?	Hospital:				e of Death (Chec	k only one)		
n of Vi ling Physi After this funeral dir	٢	1 Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day,Ye		ER/Outpatient : 28b. Time of Inju		Other Nurs		Residence 6 Othe	r.
The state of the s								unk		
Very large of the property of								ural Route Number, City augh Rd.		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Phy	sician: To the best of my	_				nd due to the caus	e(s) and manner as star	ted.
To T with To I	Med	29b. Signature and title of certifier	and manner stated.			29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)
		Caral.	Halla	V		O.C.	M.E.		May 14, 2006	
07			vho completed cause of de istant Medical Exam		^{23a)} 111 Penn St	eet, Baltim	nore, MD 212	01		:
St Regis	ate	31. Date filed (Morth Av, Year) 6	2006 32. Resistrar	s Signatu	rely does	M.				

4:15 a.m.

	P.O. Boy	et the death c
OWENS	Division of Vital Records, P.O. Box	oitai or Attending Physician: The law requires thet the death c
LOLA	of Vital	Physician: T
	Division	ital or Attending

			1 - For Stete Registrar	State of M	aryland /		artment of rtificate of		ind Mental		ene 201	06	15395	
	Physici	an	1. Decedent's Name (First, Middle, L	•					2. Date of Month			Year	3. Time of Death	
	/Medic		Lola B. Ower				I		May	14,	2006		4:15A ^M	_
	Examin	er	4a. Fecility Name (If not institution, g		1		4b. City, Town,		f Death		4c. County of			
	F		Stella Maris 5. Social Security Number 6.		ge (In yrs. last	birthday)	Towso		24 Hrs. 8. Date of	f Birth	Balti			-
	Funeral Director		226-50-5029	1□M 2X1F	65	Yrs.	Months Days	Hours	8. Date o (Month 2-1	, <i>Day</i> , 1 6 – 1	941	Countr	ce (State or Foreign y) VA	
pue	* 1	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	ocation					100	d. Inside City Limits	_
Z al	1 eho	5	MD										1 XYes 2 □ No	
ŧ.	7.28a	rec	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·	рать	TINOI	e City			10	g. Citizen of Wh	nat Countr	y?	-
, sei	3a o	JE D	6802 Eastern	Avenue			212	24			USA			
d a d	em l	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of	Hispanic Orig	in? (Specify Yes of Puerto Rican, etc.	r No-		- Americar White, et		-
36	or its		1 Never Married 2 Married	1 ☐ Yes 2 🕅 If Yes, Give			1 □ Yes 2 🛣 No		T dono moun, oto.	.,		Whit		
	urei'	d b	X☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	1	Co Desc	dealle Usual Occ							_
2 2 2 2	nedic	Completed by	(Specify only highest g	rade completed)		(Give	dent's Usual Occi kind of work don DO NOT use retir	e durina most	of working	10	3b. Kind of Busi	iness/Indu	istry	
212	than than	E	Elementary/Secondary (0-12)	College (1-4or:	5+)	Но	me Hea	1th A:	ide		Hea1	th C	lare	
ם פוויי	othe othe vent,	Bec	17. Father's Name (First, Middle, La	st)				7	's Name (First, Mi	ddle, Ma				-
/ar	Menta Irked	To E	Boyd Crouse					Eff	ie John:	son				
Baltimore, Maryland 21215-0036	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-f ehow eny injury or other treumatic event, I'm Medical Examiner must be notified at once.	. 1	19a. Informant's Name/Relationship Delores Katsil	(Type, Print) Daug	hter 1				r or Rural Route Ni					
6, 7	Health am 27 ther t		20a. Method of Disposition	cadakos_			osition (Name of	Lein F	Date Date				1D 21224	
10r	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 X Burial 2 ☐ Cremation 3		ceme	etery, crei	natory or other pl	· 1			oc. Location - C			
itin E	artme ortani injury		4 □ Donation 5 □ Other (Special Signature of Euneral Service Lice		пот		Iill Cet 2. Name and Add		5-16-06					
8	Depa Impo eny it		* The Hely						Bradle;				ral Home	
E	hysician hydician and hydicien and hydicien streethy the privat-transit streethy the private hydrogen and hyd	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	a consequence	ce of):	O PULMON.	ARY DIS	SEASE				Onset and Death	
I Records, P.O. Box 68760, The law requires the the death certificate be executed.	ed by the attending phy detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	ath 3[Ectopic pregnan	су		_	23d. Date Month		ay Year	
S , F	igned be de	þ	Part II. Other significant conditions	contributing to death b	out not resulting	g in the u	nderlying cause g	iven in Part I.					cause of death?	
Orc	been si should	eted								∐ Yes	2 L No 3	∐ Probab	dy 4 X ☐Unknown	
Rec The lay	te has l	Completed							a	Vas an utopsy erforme	prio	or to comp ath?	y findings available pletion of cause of	
ita is	tor. p	BeC	25. Was case referred to medical	4 10 10	W			26. Place	of Death Check of	s 2 X	TINO IL	1165 21		
ار م ار م	his ce I dire	2	examiner? 1 ☐ Yes 2 😿 No	Hospital: 1 ☐ Inpatie	ent 2 ER/	Outpatien	nt 3□ DOA O	ther: 4 Nurs	sing Home 5 🗆 F	Residen	ce 6 Other	(Specify)	HOSPICE	
Division of Vital Records, or Attending Physician: The law requires!	ath. r: After ti e funera		27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Inju (Month, Da on	iry 28t y Year)	o. Time of Injury	We		28d. Descr		injury occurred			
Divis lor Atte	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of inj	ury - At home, c. (Specify)	, farm, str	eet, factory, office		28f. Location City of	n (Stre Town,	et and Number State)	or Rural F	Route Number,	
] To the Hospital	hours uneref	edical C	(Check only 2 Medical Ex	Physician: To the best	t examination	dge, death	n occurred at the t	ime, date and opinion, death	place, and due to	the cau	se(s) and mann	ner as state	ed. ne cause(s)	
	4 5 9		one)	and manner sta	ated.									
5	ithin 24 hours o the Funerel ompletely filled	Mec	29b. Signature and title of certifier				29c. Licen	se number		290	. Date signed /	Month Da	nv. Year)	ĺ
는 문	within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	Med	29b. Signature and title of certifier					se number		290	Date signed (ny, Year)	
Toth	_	Mec	29b. Signature and title of certifier 30. Name and address of person wh	o completed cause of d	death (Item 23	a) (Type	D4	372	j	290	5/15		ny, Year)]
) E	within 24 To the Fu	Σ		OOD 2200 1			D4	372	J IIUM, MD		5/15		ly, Year)	

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	of Marylar		artment of I		d Mental Hy	giene 2	006	15396
	Physici		Decedent's Name (First, Middle Everett Monta		Jr				2. Date of De Month	Day	200 6	3. Time of Death
*	/Medio Examin		4a. Facility Name (If not institution				4b. City, Town,	or Location of D		-	inty of Death	
			Union Memorial	Hospital			Balt	imore			N/A	
	Funeral Director		5. Social Security Number 228-50-2197	6. Sex 1 ☑ M 2 ☐ F	7. Age (<i>In yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir (Month, Da	y, Year)	Cour	
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					I 0d. Inside City Limits
	Aaryli f sho	5	Maryland N/A	1		altimor						17√TXYes 2 🗆 No
	28a-	ect	10e. Street and Number	•			10f. Zip Code			100 Citizen	of What Cour	
	3a or	Funeral Director	Keswich Multica	re 700 W	. 40th S	Street	2121	1			USA	
	me 2	nera	11. Marital Status		edent Ever in U		Was Decedent of I	lispanic Origin	? (Specify Yes or No		Race - Americ	
036	filed within 72 hours after death with the Maryland Hygiene. Hygiene natural; or terme 23a or 28a-f show ont, the Medical Examinat ment be notified at	β	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Fried 1 ☐ Yes If Yes, Gi Year or D	2 ☑ No ive		f Yes, specify Cub I□Yes 21☑No		uerto Rican, etc.)		Black, White, ecify: Whi	
21215-003	72 ho	Completed	15. Decedent	r's Education		16a. Deced	lent's Usual Occup	oation	working	16b. Kind o	f Business/Inc	dustry
2	ithin i	npie	Elementary/Secondary (0-12)	College (life. L	kind of work done OO NOT use retire	d)	working			
2	ed wi	Co	n/a				n/a				n/a	
ב	e d a	Be	17. Father's Name (First, Middle, Everett Montagu	,	Z.,				Name (First, Middle,		,	
Maryland	should be nd Menta marked umatic ev	မ			or.	404 14 19		<u> </u>	rtha Scot			
	12.5 7 is 7 is		19a. Informant's Name/Relations Lee Owen	Broth	ner	19b. Mailin	PO Box	and Number of 191 Gib	r Rural Route Numbe son Islan	d, MD	wn, State, Zip 21056	Code)
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 DRemoval from		Place of Dispo- cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location	on - City or To	wn, State
Ě	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		4 Donation 5 Other (S)			11ywoo	d Cemete	ry 5/	15/2006	Richro	ond. V	irginia
Ball	permit. F Departm Importar any injur		21. Signature of Funeral Service	Licensee	1	22 R	Name and Addre	ss of Facility	+ a F			
	707 = a		samt!	- Corpent	u		631 Fa11	s Road.	tz Funera Baltimor	ı поте 2. Mar	, inc. vland	21211
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	The state of the s	un. Do not ente	er the mode or dyn	ng, such as car	diac or respiratory a	rrest,	,	Interval Between
ا (Physician		Immediate Cause (Final disease or condition	a. /	DNE	UMC	AIME					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						
	,†	-e	Sequentially list conditions,	b	for an a common							
2	led sit	nine	ii any, leauring to immediate cause. Enter Underlying Cause (Disease or injury	D09 10	(or as a consec	(uence or):						
10	xecul and If-tra	Examin	that initiated events resulting in death) Last	c. Due to	(or as a consec	ruence of):					-	
8/60,	cate be executed physician and the buriat-transit	<u>ea</u>			•	, .						
		edicai		d								
ŏ	death certifi e attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy				234	Date of delive	201
ň	death a atte	ciai	in the past 12 months?	4 ☐ Pregi	birth 2 ☐ Feta nant at time of c		Ectopic pregnance Other (specify)	/			Month	Day Year
	oy the achee	hys	9 Unknown	9□ Unkn	nown							
, C	w requires that the de been signed by the s should be detached	by P	Part II. Other significant condition	ns contributing to d	leath but not res	sulting in the ur	derlying cause giv	en in Part I.	23e. Did to	obacco use c	ontribute to th	ne cause of death?
cords,	quire an sig uld b								_ 1 _ 1	res 2 □ No	3 ☐ Prob	ably 4 Unknown
ပ္ပ	law re as bee 2 sho	Completed							24a. Was		b. Were auto	psy findings available
Ť	0 2 0	E						-		rmed?	prior to cor death?	mpletion of cause of
	ician: Th	a	25. Was case referred to medical					26. Place of	1 ☐ Yes Death Check only o	nel No	1 🗆 Yes	2) No
>	Physician: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 ▼ No	Hospital:	atient 2	ER/Outpatient	3□ DOA Oth		g Home 5 ☐ Resid		Other (Specifi	v)
ם ר	ng Pt ter th neral		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	28c, Injui Woi		28d. Describe h			,
<u> </u>	endir sath. he fu	atic	1 Panatural 5 ☐ Pending 2 ☐ Accident investig	jation	.,, ,			Yes 2 □ No				
DIVISION	l or Atte efter de Directo	ertification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 286. Place	e of Injury - At hing, etc. (Specil	ome, farm, stre fy)	eet, factory, office	1000	28f. Location (5 City or Tox	Street and Nu vn, State)	mber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours elfar death To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	examiner: On the b	e best of my kno pasis of examina aner stated.	owledge, death ation and/or inv	occurred at the tidestigation, in my co	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) and date and place	manner as st	ated. the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier				29c. Licens	e number			ned (Month, I	
			> A Wallen	mana	NO1	0	D 4	7/23	/	YAY	11,20	006
	7		30. Name and address of person	who completed caus	se of death (Item	n 23a) (Type, F	Print)	110.00	201. F.	UNIV	PKW	Y
	6		JOSEPH PC 31. Date filed (Month, Day, Year)	THUMY	4 /√∕∕⁄ pgistrar's Signa	UNION	MEM	1405P.	BALTIN	AORE,	MIDS	21.215
	Sta Registr		MΔY 1	Acc	Comments Signa	1 do	and a					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	larylan		artment <i>rtificate</i>				Re	eg. No UU6	15397
	Physici /Medic		Decedent's Name (First, Middle, La FRANCES	*	•	01	BERMAN				Date of Deat 1AY 12,		3. Time of Death 8:40 Å M
	Examir		4a. Facility Name (If not institution, given RUXTON PIKESVILI 5. Social Security Number 6.5	E NURSING	HOME		PIK	ESVI				4c. County of Death BALTIMORE	
	Funeral Director			7. A	89 (<i>in yrs. i</i>	9 Yrs.		Days	Hours		Date of Birth	1916 9. Birth	place (State or Foreign NY
	Maryland I show	tor	10a. State 10b. County	IMORE	10c. City	y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	3a or 28s	I Direc	10e. Street and Number 3710 BRETON WAY				10f. Zip (21208		10	Og. Citizen of What Cou	ntry? USA
396	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Madical Expiritive must be notilized at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 W If Yes, Give Year or Dates:	? INo		Was Decede	nt of His y Cuban		n? (Specify Puerto Ric	/ Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify:	can Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Menhal Hygiene. I and Menhal Hygiene is marked other then "natural", or items 23a or 28a-f show eumatic event, Ins Marolfal Exhibiter must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation		(Give	dent's Usual kind of work DO NOT use AKER	done du	ion ring most of	of working		16b. Kind of Business/Ir	dustry
land 2	uld be filed Mental Hygi irked other itic event, I	To Be C	17. Father's Name (First, Middle, Last, BEN)	ВЕ	ENJAMI		1	18. Mother's KATI		irst, Middle, N	faiden Sumame)	OREMAN
	# 12 B		19a. Informant's Name/Relationship (SUE BRAZIUS / DA	Type, Print) UGHTER								City or Town, State, Zip	Code)
altimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other OUGE.		20a. Method of Disposition 1		CE	lace of Dispo emetery, cred	natory or oth	er place)		Date 5/15/2		Oc. Location - City or To	
Balti	permit. Departm Importa eny Inju		21. Signature of Funeral Service Lice	The second		22	2. Name and	Address	of Facility	SOL L	EVINSO	N & BROS., KESVILLE, I	INC.
	Physician		23a. Part . Inter he disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	d the death line.	. Do not ent	er the mode	of dying,	such as car	rdiac or re		st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as									
8760, 4	death certificate be executed e attending physician and ad for use as the burial-transit	al Examiner	Sequentially list conditions, Tany, Jacob of Himbolatt cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as									
ox 687	leath certificate I attending physi I for use as the t	/Medical	IF FEMALE:	23c. If yes, outcome	of pregnar	nev						T	
.o.	at the death by the atter tached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic preg Other (s <i>pec</i>					23d. Date of delive Month	Day Year
rds, P	ires the signed d be de	þ	Part II, Other significant conditions of	ontributing to death t	Ps 40	Iting in the un	nderlying cau	ise given	in Part I.			acco use contribute to the	
Y	The ete h page	Completed									24a. Was an autopsy perform	ed? death?	psy findings available impletion of cause of 2 No
<u> </u>	Physician: The this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Other:		- 177	neck only one		
	After fune	\vdash	27. Manne of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju	ıry	ER/Outpatien 28b. Time of Injury		: Injury a Work?	4 Nursin	28d.		ice 6 Other (Specify vinjury occurred	ν)
-	= = = -	Certification:	3 Suicide 6 Could not by determined	286. Place of In	jury - At hor tc. (Specify)	me, farm, stre	eet, factory, o	office		28f.	Location (Stre City or Town,	991 and Number or Rura State)	l Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	one)	ysician: To the best niner: On the basis of and manner st	n examinati	viedge, death on and/or inv	occurred at estigation, in	the time, my opin	date and pl	lace, and occurred a	due to the cau t the time, dat	use(s) and manner as si e and place, and due to	ated. the cause(s)
	To T Com	2	29b. Signature and title of certifier	Lalle	an,	nn)		icense r		_	290	d. Date signed (Month,	Day, Year)
	9		30. Name and address of person who TAINEEN (31. Date filed (Month, Day, Year)	completed cause of a	death (Item	23a) (Type, I	PARA	c H	E19	OHIS	AVE, A	BAETO MI	21208
	Sta Registr	re	31. Date filed (Month, Day, Year) MAY 1 6 2006	32. Registr	rar's Signatu	Joseph .	را						

Please Type or Print in Black Indelible Ink

Robert Jonathan		essell 1- For State	State of Mary	land / Dep	artment of	f Healtl	n and	Mental I	Hygiene	2	0.0	(1500
Physicia		Registrar 1. Decedent's Name (First, Mi	ddle,Last) Poh	ert John F		Deau			2. Date of De	Reg. No.	UU	3. Time of Death
Medical Exami	ner	Robert Jo	hnathan	Press					Month May 14,	Day Ye 2006	ar	1745 hrs
k		4a. Facility Name (if not institu		number)			own, or Lo	cation of Dea	th	4c. County	of Death	
Formeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Unde		If Under 24H	rs 8 Date of F	lirth (MM/DD/YYY	v) a Rint	nnlace (State or
Funeral Director		217 26 1828	1 M 2 F		'3 Yrs	Months	_	Hours M		19,1932	Foreigr Cou	ntrMaryland
any		Usual Residence of Decedent 10a. State 10b. Coun		10c City	y, Town or Locat	ion						10d. Inside City Limits
*	L	Maryland	.,		timore							1 XYes 2 No
Aarylan 28a-f s 1 at on	Director	10e. Street and Number	•			10f. Zip		1011		10g. Citizen of W		try?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infortant: I fitten 27 hand to file marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	_	6427 Glenoak 11. Marital Status		ecedent Ever in U	10 112 W	Donadar		1214	Sansify Von an h		JSA	an Indian, Black,
leath w	Funera	1 Never Married 2	A	Forces?					Specify Yes or N to Rican, etc.)		te, etc.	all Illulais, Diack,
after d	by F		Divorced If Yes, Give Y	^{rear} 1952–5		Yes 2					Whit	
hours "natur	ted	 Decedent's Education (S Elementary/Secondary (0-1 		rade completed)	16a. Deceder during m			n (Give kind o O NOT use r		16b. Kind of B	usiness/In	dustry
336 thin 72 re. than edical	Completed	8	2) 0011090	(1-4-01-0-)	Owne:	r / 0	pera	tor		Carpe	ntrv	,
5-0036 lied within 7 Hygiene. I other than		17. Father's Name (First, Midd	ile, Last)		1 0,1120.				ne (First, Middle	, Maiden Surname		· · · · · · · · · · · · · · · · · · ·
2121 ould be fil Mental I marked	o Be	Milton 19a. Informant's Name/Relation	Pressell		10h Mailin	n Address	/Stroot s	The	eresa	Ritter umber, City or Tov	en State	Zin Codo)
MD 2 d 2 shou lth and h n 27 is n	ţ	Delmund Press		(son)	19.					od, Mary		
re, N I and I'Healt I'item er trau		20a. Method of Disposition 1 XXBurial 2 Crema		20b	. Place of Dispos crematory or of	sition (Nam	e of ceme	etery,	Date	20c. Location	- City or 1	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other		Ga	rdens o	f Fai	th C	em. May	y 17 , 200)6 Baltin	nore,	Maryland
Balt permit. Departs Import		2 Signature Funeral S IV	ce Licensee	9		Name and		•				Home PA
Physician		23 Pan I. Enter the disease		raused the deat	h. Do not enter t	the mode o	C Eas f dying, su	stern 1 uch as cardiad	or respiratory a	rrest, shock, or he	eart	Approximate Interval
/Medical Examiner	1	ailure. List only one cau	Ashanaa	erotic Cardio	vascular Dis	ease						Between Onset and Death
LXammet		or condition resulting in death	. Doo to (of a	s a consequence	of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau		s a consequence	of):							
	Examiner	(Disease or injury that initiate events resulting in death) La	d ^{C.}	s a consequence	of):							
be executed ician and irial - transit			d	•	1	(
0, cb execut	edical	UNPENDED	X AMENDE		perME,g85	55,5/22	2/06 T	T		1		
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hoursel. After this certificate has been signed by the attending physicompletely filled in by the funeral director, Aget to see 2 should be detached for use as the bu	cian/Me	IF FEMALE: 23b. Was decedent pregnant i past 12 months?	n tho	s, outcome of pre e birth		etal death	3	Ectopic preg	nancy	23d. Date o Month		ay Year
Box 6 e death ce the attend	sici		Inknown de	egnant at time of ath known	5 0	ther (Spec	ify)					
O. B at the d i by the tached	, Physi	Part II. Other significant con		g to death but not	resulting in the	underlying	cause giv	en in Part I.	23e. Did	tobacco use cont	ribute to t	he cause of death?
s, P.O. iires that t' i signed by	d by								1 Y	es 2 No 3	Proba	ably 4 🗹 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should I	Completed									opsy	prior to co	opsy findings available empletion of cause of
Rec The la ficate h	Com								1 Yes	formed? 2 V N	death?	2 No
Vital Rec ysician: The I his certificate I	Be	25. Was case referred to med examiner?	Hospital:	Inpatient 2	ER/Outpatien			f Death (Chec	sing Home 5	Residence 6	✓ Other:	Scene
of V ig Phy ifter thi	: To	1 Yes 2 No 27. Manner of Death	28a. Da	ate of Injury	28b. Time of		8c. Injury			how injury occur		
ion trendin leath. for: A	atior		ending vestigation	mici, Day, real)	- : -		1 Ye	s 2 No				
Division of ¹ To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After t completely filled in by the funeral	Certification:	3 Suicide 6 C	ould not be 28e. P	lace of Injury - At	home, farm, stre	et, factory,	office bui	lding, etc.	28f. Location or Town,		oer or Run	al Route Number, City
lospite 4 hours unera		29a. Certifier 1 Continue	Physician: To the I		dge, death occu	rred at the	time, date	and place, a	nd due to the car	use(s) and manne	er as starte	ed.
o the I ithin 2. o the F	Medical		xaminer: On the bas	is of examination								
F 3 F 3	Me	29b. Signature and title of cer		ANA RU	B10	29c	License			29d. Date sign		th, Day, Year)
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		mes		MARGARI		CL	O.C.M	.E.		May 16, 20	UU6	
1011		30. Name and address of personal Margarita Korell MD		ause of death (Ite ledical Exami		enn Str	eet, Bal	timore, MI	21201			
	tate		·	Registrar's Signa	ature	Se J						/
Regis	ueu	IVI IA T	IN ZULLO LASS	Wirth 15 3 &	A STATE OF THE PARTY OF THE PAR	A PORTOR						12

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fly 8855 5-25-06 vt
State of Maryland Pleastment of Health and Mental Hygiene

			1 - For State Registrar	State of Marylar		artment of F rtificate of			iene g. No. 2 0 0 (5 15399
	Physic /Medi		1. Decedent's Name <i>(First, Middl</i> e, Las Mary Lo	•				2. Date of Deat May 9,	2886 Ye	3. Time of Death 2:11 A M
	Exami		4a. Facility Name (If not institution, give Southern Marylan		-	4b. City, Town, o		ath	4c. County of D	
	Funeral Director		102 01 0110	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 9.	Birthplace (State or Foreign Country) Entucky
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	ty, Town or Lo	cation per Marl	boro			10d. Inside City Limits 1 ☐ Yes ❤️ No
	th with the 23a or 28e	Funeral Director	10e. Street and Number 11917 Berrybr	ook Terrace	-	10f. Zip Code 20772			Og. Citizen of What United St	Country?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28e-1 show or other treumatic event, the Modical Evarul ar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2/19 No If Yes, Give Year or Dates;	1	Vas Decedent of H f Yes, specify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc. White
21215-0036	within 72 horane. sne. then "natura	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	cation de completed) College (1-4or 5+)	(Give life. [lent's Usual Occupa kind of work done of OO NOT use retired	furing most of wo)	orking	6b. Kind of Busine	ss/Industry
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, I'm M.	To Be Co	17. Father's Name (First, Middle, Last) Ernest C. Sta	11man	l Bu	dget Ana	18. Mother's Na	ame (First, Middle, N	la <i>id</i> en Sumame)	Navy
	and 2 shouealth and New 27 is mail		19a. Informant's Name/Relationship (T) Frank Parks (Son				nd Number or F	Rural Route Number,	City or Town, State	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tree		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Le	emetery, crem ee Crem	sition (Name of natory or other place atory May	21, 20	06	Oc. Location - City Clinton	, MD
Bal	Depar Impor any in		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or comp	Sibles mois	84 A	lexandria	Ferry :	e Funeral Road, Clin	nton, MD	20735
	Physician /Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. ACUTE Due to (or as a conseq	Pu	IL MON		EMBOLIS		Approximate Interval Between Onset and Death I ##.
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence)						
.O. Box	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknow,	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
rds, P	w requires that been signed t should be det	þ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did toba	4.0	to the cause of death? Probably 4 □Unknown
of Vital Records,		e Completed	25. Was case referred to medical					24a. Was an autopsy performe	prior to	
ion of Vit	Phys this aldii	To B	examiner?		ER/Outpatient 28b. Time of Injury	28c. Injury Work	T 4 ☐ Nursing H	ath Check only one. Home 5 Residen 28d. Describe how		ecify)
Division	in the co	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral C completely filled i	Medical	onel	sicien: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or inve	estigation, in my opi	nion, death occu	irred at the time, date	and place, and du	ie to the cause(s)
)	N Wil		30. Name and address of person who con the LS on BE 1. 31. Date filed (Month, Day, Year)	w M.D.		D 2	828	290	Date signed (Mor	1th, Day, Year)
	8		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, P	SCATAN	AY RO	AD, CC	INTON,	MD 20735
	Sta Registr	te ar	MAY 1 6 20	32. Hegistrar's Signat	the do	while				

2. Dete of Deeth

1	3.	Time	of E	Death	1
	Bernglerer.		L	0	0

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	aryland	irecto
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene.	Important: If Item 27 is marked other then "natural", or Items 23a or 28a-4 show any injury or other traumatic event, the Medical Evarriner must be notified at
and 21215-00	be filed within 72 hountal Hydiene.	d other then "natura event, the Medical E
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hydiene.	nt: If Item 27 is markery or other traumatic
Balti	permit. Departm	importai any inju

1. Decedent's Name (First, Middle, Lest)

7.7	Physic /Medi	cal	Helen H	I. Perkins	S		4b. City, Town, or Lo	May 1	4, 200 4c. Count		1:20 PM
	Exami	ner	Maryland Masor			ĺ	Cockeysv			Baltin	moro
	Funeral Director		Social Security Number 6. Sex		yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day FEB 24.	Year)	9. Birthplace Country)	o (State or Foreigr 71and
	P.		Usual Residence of Decedent 10a. State 10b. County	140	City Town and a			FED 24,	1910		
	Manyla f show	ō			c. City, Town or Loc						Inside City Limits 1 ☐ Yes 2 🕱 No
	r 28a-	Director	Maryland Baltimo	ле		10f. Zip Code	ckeysville		l 0g. Citizen of	What Country?	
	th with	ai D	300 International	Circle, R	oom 136		21030		U	SA	
20	iges 1 end 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 Is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evantiner must be notified at	by Funeral	1 Never Married 2 Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates:	If	Ves Decedent of H Yes, specify Cub. ☐ Yes 2X No	Hispanic Origin? (Spean, Mexicen, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra	ce - American I ck, White, etc.	ndian,
Maryland 21215-0020	72 hour natural' dicel Ex	Completed b	3 X Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grede	ation	16e. Decede	ent's Usual Occup	pation during most of workii d)	na l		White usiness/Indust	
121	within ene. then	шp	Elementary/Secondary (0-12)	College (1-4or 5+)				.9			
5	Hygie other	Be Co	17. Father's Name (First, Middle, Last)		Su	perviso	18. Mother's Name	(First, Middle,		ail Sto	re
<u>Jan</u>	uld be Aental rked o	To B	Harry W	. Hamill				Lucie	H. Way	,	
ar	2 should and Men is marked		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Street	and Number or Rura			, State, Zip Coo	de)
	end lealth m 27 her tr		Helen P. Berry/D			Dixie I	Orive Bis	hopvill			
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	•	etory or other pla				- City or Town,	
=======================================	- 투원를 :		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	The state of the s	letro Cre	natory, Name and Addre		/15/06		imore,	
Ba	permit. Departrimports any inju		Esliver of A Drey	now			, 01	emation		•	,
-Six	3.		Edward A Greg 23a. Pert1. Enter the diseese, or complic shock, or heart failure. List only one	Orchik ations that caused the o			erick Road			MD 2122	oroximate
American Paris	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death) e.				ease in Disee			Inte	erval Between set and Death
) ·	be sit	liner	_ h	ATherSo	cloter V	asarlo	n Disee	re			
60, 1,	be executed Icien and burial-trensit	al Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		to (or as a consequ						
Box 68/60,	the death certificate be executed y the attending physicien and sched for use es the burial-trensit	nysician/Medical	that initiated events resulting in death) Last	Due to	o (or as a conseque	ence of):					
	death e atter	siciar	Part II. Other significant conditions conti	ributing to death but not	resulting in the unc	lerlying cause giv	en in Part I	23h Didto	hecco use co	ntribute to the	cause of deeth?
s, P.C.		<u>a</u>	11	1		1				3 Probably	
Hecords	law requires that th as been signed by a 2 should be detect	Completed by	fractives , h10	no Brea ofterpri	iois, b,	10 phel	ntis	24a. Was e	n autopsy ned?	aveileb	utopsy findings le prior to tion of cause 1?
<u> </u>	The ate h page	Con	V					1 □ Y€	s 2 No	1 □ Ye	s 200 No
VITA	Iclan: Sertific Pector,	Be	25. Was case referred to medical examiner?	spital:		Oth	26. Plece of Death				
on or	iling PI After th funere	tion: To	1 Yes 2 No	1 ☐ Inpatient 2 28e. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of Injury	3 DOA Other	4 A Nursing Hom	e 5 Reside 8d. Describe ho			
DIVISION	To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, stree ecify)			8f. Location (Sti City or Town	eet and Numb , Stete)	er or Rural Rou	ite Number,
	To the Hospital or within 24 hours efte To the Funerel Dirk completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	clen: To the best of my ler: On the basis of examend manner stated.	knowledge, death on nination end/or inves	ccurred at the tim stigation, in my op	ne, dete and place, ar pinion, death occurre	nd due to the ca d at the time, da	use(s) and ma ite end place, a	nner as stated and due to the	cause(s)
	Tot Tot Com	Σ	29b. Signature end title of certifier	_		29c. License	e number	29	d. Date signed	d (Month, Dey,	Year)
)			K.T. Fiber	D _{ms} .		Dai	146x		5/15/	166	
	V.		30. Neme and eddress of person who com PoBert L 13eth, M 31. Date filed (460th, Day, Year)	10. 3508	Bank St	int) : Bali	to, and	242	y'		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrer's Si	gnature			4			

DHMH 16 Rev 6/95

State Registrar

				1 - For State Registrer	State	of Mai		epartmer Certificat		lealth and N Death	Mental Hy	giene Reg. No.	06	154	0
_		Physici /Medic		Decedent's Name (First, Middle, Last, PIERA	FII	ΝA		PISC	IOIT	A	2. Date of De Month MAY	Day	06 Year	3. Time of I 2:50	
		Examin		4a. Facility Name (If not institution, give GILCHRIST HOSPIC					TO	r Location of Death			y of Death BALTI	MORE	
		Funeral Director		210-44-0041	M 2 X F	7. Age	(In yrs. last birth 77 Yı	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bit 1 1 -8 - 1	928"	9. Births	place (State or ALY	Foreign
		Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTIM	ORE		10c. City, Town			ALE			1	l0d. Inside Cit	
		with the 3a or 28a 1 be notifi	I Direc	10e. Street and Number 1519 CUSTOMS ROA	D			10f. Zip	Code 2123	37		10g. Citizen of	What Cour	•	
	36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Itiem 27 Is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. The Medical Exa., it et mat be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Dec Armed F	orces? 2X\ No ive		13. Was Dece If Yes, spe	dent of H cify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Ra	ce - Americ ck, White,	an Indian,	
	21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) (1-4or 5+)		ecedent's Usu Give kind of wo ife. DO NOT u	nk done d se retired	ation during most of work d)	ing	16b. Kind of £	Business/In	ŕ	
	Maryland 2	uld be filed Mental Hygi irked other	To Be Co	17. Father's Name (First, Middle, Last) CALOGERO	Ŋ	MANGI	ONE			18. Mother's Nam		, Maiden Suma			
		9 5 N 2		19a. Informant's Name/Relationship (Ty ANTONINO PISCIOTI		BAND		Mailing Address	•	and Number or Rui	al Route Numb ROSEDAL		, State, Zip 212	,	
	Baltimore,	permit. Pages 1 and Department of Heall important: If item 2 any injury or other ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☒️Other (Specify)			-	isposition (National Crematory or Control Con	ther plac	e)	Date 7–2006	20c. Location TIMONI	-)
	Balti	permit. Departm importa any inju		21. Signatur				22. Name ar	d Addres	ss of Facility CV	ACH/ROS	EDALE F	UNERA	L HOME 21237	
3		Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that le cause on	caused the	hem			g, such as cardiac				Approximate Interval Betw Onset and D	reen
506		/Medical Examiner		resulting in death) Eequentially list soundtions,	Due to	,	consequence of	,							
06 Q	8760,	ate be executed hysician and the burial-transit	Ical Examiner	Edgentially liet so notions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			consequence of)								
5/14	.O. Box 68	ath certific attending p for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 nant at tir	pregnancy Fetal death me of death	3 ☐ Ectopic pi 5 ☐ Other (sp				l l	ate of delive	-	ear ear
3	rds, P	n requires that the de been signed by the s should be detached	by	Part II. Other significant conditions cor	tributing to o	ieath but	not resulting in the	ne underlying o	ause give	en in Part I.	1	obacco use con Yes 2 No	-		
pier	al Records,		Completed								24a. Was autor perfo 1 ☐ Yes	osy ormed?	prior to cor death?	psy findings a npletion of car 2/2 No	vailable use of
3	of Vita	Physician: Th this certificate al director, pag	To Be	1 195 2 2 100		Inpatient		atient 3 DC	Othe	26. Place of Deat er: 4 \(\sum \) Nursing Ho			ner (Specif)	Hosp	ICE
Sciott	Division o	Attanding I r death. ector: After by the funer	ertification:	27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date (Mor	e of Injury	/ - At home, farm	М		/ at k? Yes 2 □ No	28f. Location (now injury occur		l Route Numb	er,
Pisc	Ö	To the Hospital or A within 24 hours after to the Funeral Directompletely filled in by	dical Cert	29a. Certifier 1 Certifying Physical (Check only 2 Medicel Exeminate)	icien: To th	ling, etc. e best of example of e	my knowledge. o	leath occurred	at the tim	ne, date and place,	City or Ton	causo(s) and m	anner as st	ated.	
		To the Hospital within 24 hours a To the Funaral Completely filled	Med	one) 29b. Signature and title of pertifier	and mar	ner state	od.	290	. License	number		29d. Date signe	d (Month,	Day, Year)	
	10	, 7		30. Name and address of person who co	mpleted cau	se of dea	th (Item 23a) (Ty			N. CHAR	LES STR		13,0	×6 0 3	
	:	Sta	- 20	DK. HNTHONY 31. Date filed (Month, Day, Year)	K1/t	Registrar'	M: />, s Signature		OWS	CON, MD	2120	4			
		Registr	ar .	MAY 1 6 2006	March	ند تساد	J. April								1 m

State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Stephen Piotrowski May 15, 2006 4:00 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7826 Eddlynch Rd. Baltimore Dundalk 8. Date of Birth (Month, Day, Year)
Sept. 23, 1923 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Months 1**☑**M 2□F 82 Director Yrs 216-16-1142 Md. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ral, or items 23a or 28a-f show Director 1 ☐ Yes 2 ☑ No Md. Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7826 Eddlynch Rd. 21222 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after cannot of Health and Merial Hygiene.
ant: if item 27 is marked other than "natural", or item
ury or other traumatic event, the Medical Establing. 1 Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9 yrs. College (1-4or 5+) Technician Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Z. Piotrowski Sr. 2 Stella Kowalczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Josephine C. Piotrowski 7826 Eddlynch Rd. Dundalk Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 19 2006 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Dundalk 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Fueral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part . Enter the disease, of complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOMYOPA **Physician** disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially standardines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 100 23d. Date of delivery 3 Ectopic pregnancy Year Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 -NO 3 ☐ Probably 4 ☐ Unknown THRI 7.E 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 PNo 25. Was case referred to medical examiner?

1 Yes 2 No Certification: To Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 TYes 2 TNo 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 252379 son who completed cause of death (Item 23a) (Type Print)
HIV WAND A 1124 Male AVENUE 30. Name and address of pers SHIVMINDA 31. Date filed (Month, Day, Year) MAY 1 6 2006 Registrar's Signature State Registrar

06-03203 Jerimiah Pinder Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

ilinair i ilidei		1- For State Registrar	Cei	rtificate of D		ontain i		g. No.	00	6 1540
Physicia	an/	Decedent's Name (First, Middle, I	Jermman Lr	nder			Date of Deat Month	Day Y	ear	3. Time of Death 1045 hrs
edical Exami	ner	Jeremiah W 4a. Facility Name (if not institution,	· · · · · · · · · · · · · · · · · · ·	4b.	City, Town, or Locat	ion of Death	May 12, 20		y of Death	1045 1115
		Shock Trauma Intensive			Baltimore					
Funeral		6510	Sex 7. Age (In yrs. 1			Under 24Hrs.	8. Date of Birt	h(MM/DD/YY	YY) 9. Birt Foreig	hplace (State or n
Director		219-52- 6910-	1 X M 2 F 56	Yrs.			12-25	-1949	Cou	untry) MD
any		Usual Residence of Decedent 10a State 10b. County	10c. City	, Town or Location						10d. Inside City Limits
Maryland 28a-f show any 1 at once.	ē	MD	Ва	ltimore						1 X Yes 2 No
Maryla r 28a-f ed at o	Director	10e. Street and Number		1	Of. Zip Code		10	g. Citizen of \		itry?
ith the		3403 Round Road	12, Was Decedent Ever in U	S 13 Was D	21225 ecedent of Hispanic	Origin? (Sn	ecify Yes or No	USA 14 Ra		can Indian, Black,
leath w	Funeral	1 Never Married 2 X Marr			specify Cuban, Mex				nite, etc.	Sair malan, Diagn,
after d	by F	3 Widowed 4 Divor	ced If Yes, Give Year or Dates:		es 2 X No spe			Specify	DI	ack
hours natur		15. Decedent's Education (Specification Elementary/Secondary (0-12)	y only highest grade completed) College (1-4 or 5+)		Usual Occupation (G of working life. DO N			16b. Kind of I	Business/li	ndustry
336 thin 72 re. than '	ompleted	11	College (1-4 of 5 t)	Welde	r			Beth1	Lehem	Stee1
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ	17. Father's Name (First, Middle, La	ast)			other's Name	(First, Middle, M			
2121 Ould be fi Mantal marked ic event,	o Be	George Pinder 19a. Informant's Name/Relationship	n (Tyne Print)	I 19b Mailing A	Ma ddress (Street and	Number or B		ber City or To	own State	Zin Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	_		Williams/Siste							
Baltimore, MD 21215-0036 Demmit. Pages I and 2 shoulate Hied within 72 hours after death with the Maryland Department of Health and Montale Higher what I have a short in the Maryland important. If item 27 is marked other than "natural", or items 23a or 28a-f shon injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation	20b.		n (Name of cemeter)		Date	20c. Location		
imo Pages ment o tant:		4 Donation 5 Other Spec	cify: Cr		e Vet. Cer		-19-06	Crow	nsvil	le, MD
Baltimore, MD 21215-0036 Depenit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiewick in finem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. S nature of Funeral Service Li	censee		e and Address of Fa	Jai				ns F.H.,Inc
Physician		23a Fart I. Enter the disease, or co			_31 Laure mode of dying, such					21217 Approximate Interval
/Medical Examiner		failure. List only one cause or Immediate Cause (Final disease	a Multiple Sharp Force Ir	njuries with Co	mplications					Between Onset and Death
zadililioi		or condition resulting in death)	Due to (or as a consequence of	of):						
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of	of):					-	
executed an and al - transit			d							
760, icate be executed physician and the burial - transit	Medical	UNPENDED	x AMENDED 5 per		–16–06 vt	item	#1,perME,			
Sox 68760, death certificate be reattending physici for use as the buri	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth	gnancy 2 Fetal	death 3 Ec	ctopic pregna	incy	23d Date Month		ay Year
Box 68 death certif the attending	Physician	1 Yes 2 No 9 Unknown	Pregnant at time of do	eath 5 Other	(Specify)			1		
4 8		Part II. Other significant conditio		resulting in the und	erlying cause given i	in Part I.	23e. Did to	bacco use cor	ntribute to f	the cause of death?
S igi	d by						1 Yes	2 🗸 No	3 Prob	ably 4 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should i	Completed	·					24a. Was autop	sy	prior to o	topsy findings available ompletion of cause of
Reco	E O.						1 V Yes		death? 1 ✓ Ye	s 2 No
ital ician: s certifi rector,	a B	25. Was case referred to medical examiner?	Hospital: 1 ✓ Inpatient 2	ER/Outpatient 3	26.Place of De			Residence 6	Other	
of V ing Phys After thi	٦ ٢	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Inju		Work?	28d. Describe t	low injury occu	urred	
- <u>-</u> - ₹ - 3	tion	1 Natural 5 Pendir 2 Accident Investi		1301 hrs	1 Yes 2	2 🗸 No	Subject stat	bed and c	ut	
Division tal or Attendium rs after death all Director:	Certification:	3 Suicide 6 Could	not be 28e. Place of Injury - At h		actory, office buildin	- 1	or Town, S	tate)		ral Route Number, City
E G G		4 Homicide determ 29a. Certifier 1 Certifying Phy	(Specify) Single Far		l at the time, data an		3403 Round			
To the Hos within 24 h To the Fur completely	Medical		iner:On the basis of examination							
To wii	№	296. Signature and title of certifier	and manner stated.		29c. License nun	mber		29d. Date sig	gned (Mor	oth, Day, Year)
X	1	1 Conter	verne)		O.C.M.E.			May 13, 2	2006	
カオー	1	30 Name and address of person w Laron Locke MD. As	who completed cause of death (Iter sistant Medical Examiner		treet, Baltimore	e. MD 212	01			
J'	tate	21 Date filed (More Serve Veer)	22 Parts Signed		LICE, Dalariole	, IVID Z IZ				
Regis		ST. Date med (IVIO) M. A.V. Tai) 6	2006 Server 32. Inglish at 3 signal	K Som	12.0					

			1- For State of M		artment of Health and rtificate of Death		ene 200	6 15401
	Physic	ian	Decedent's Name (First, Middle, Last)		***************************************	2. Date of Deatl	Day Year	3. Time of Death
	/Medi		MILLER PARSON			MAY	12 200	
الم	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dear	th	4c. County of Dea	ath
			FUTURECARE-SANDTOWN		BALTIMORE			
	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 7. A Usual Residence of Decedent	ge (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Bi C	nthplace (State or Foreign ountry)
	within 72 hours after deeth with the Maryland ene. than 'natural', or Items 23a or 28a-1 show ite Madical Examinat the reutiled at		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Man	ģ	MD	BALTI	MORE			1 X Yes 2 □ No
	h the	Director	10e. Street and Number	DAULL	10f. Zip Code	10	g. Citizen of What C	ountry?
	th will		701 N. ARLINGTON AVENUE	APT. 411	21217		USA	
	ee E	Funeral	11. Marital Status 12. Was Decedent Armed Forces'	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am	
9	or It	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐	No	1 ☐ Yes 2 【X No Specify:	to Alcan, etc.)	Black, Whi	te, etc.
Ö	ural	d by	3 Vidowed 4 Divorced Year or Dates:	1945-46	••		Specify:	BLACK
7	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 1	6b. Kind of Business	/Industry
12	withi Bne.	E G	Elementary/Secondary (0-12) College (1-4or	5+)	BORER		CONCEDITO	TON
<u>0</u>	Hygin Hygin		17. Father's Name (First, Middle, Last)	LA.		me (First, Middle, M	CONSTRUC	TION
a	lid be lental ked c	To Be	WILLIAM PARSON			E McCLARY		
	should and Men s marke umatic	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Ru			Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural; or Items 23a or 28a-f ehow entry fourly or other traumatic event, the Macitial Examinat must be resulted at once.		TERAH PARSON/WIFE		N. ARLINGTON AVE.			RE, MD 21217
o e	of He of He roth		20a. Method of Disposition 1 反 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place)	Date 2	0c. Location - City or	Town, State
Ĕ	Pages ment of ant: If It ury or o		4 □ Donation 5 □ Other (Specify)	1		-19-06	OWINGS MI	LLS, MD
a H	permit. Departr Imports eny Inje		21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility JA	MES A. MO	RTON & SO	NS F.H., INC.
	E 2 5 0		James 9. mjo		1701-31 LAURENS S		MORE, MD	21217
			23a. Part Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not ent ne.				Approximate Interval Between
3	hysician		Immediate Cause (Final disease or condition resulting in death)	rm.not	prostate CA	NCER	with	Onset and Death
	/Medical Examiner		Due to (or as	a consequence of):	prostate CA	-	netastans	
		<u>.</u>	Sequentially list conditions, b.	a consequence of).				
	uted Insit	i	cause. Enter Underlying Cause (Disease or injury	a consequence on.				
Ć,	be executed sicien and burial-transit	Examiner	that initiated events	a consequence of):				
8760	death certificate be executed e ettending physicien and of for use as the burial-transit	dicai	d					
89	ntifica ng ph as th	Jedi	IE SELWIS					
Вох	eath certific ettending p I for use as	ar/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome 1 □ Live birth		Ectopic pregnancy		23d. Date of del	ivery
	at the dea by the et tached fo	Sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at		Other (specify)		Month	Day Year
0.	d by I	Physician/Med	9 Unknown					
Vital Records,	The faw requires that the tee has been signed by the sage 2 should be detached.	by	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	iderlying cause given in Part I.		cco use contribute to	
Š	w require been si should t	Completed					2UN0 3UPI	obably 4 Unknown
ĕ	The raw sate has page 2 s	E P				24a. Was an autopsy	prior to d	topsy findings available completion of cause of
		e Co	OS IMPO CONTRACTOR OF THE CONT			performe		20 No
= :	ysicien: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	-t «FISNO:		th Check only one		
ō	5 ਦੇ ਲ	-	27. Manner of Death 1 Natural 5 Pending (Month, Da	nt 2 ER/Outpatien	Other: 4 Mursing H	ome 5 Residence 28d. Describe how	injury occurred	cify)
<u></u>	nding ath. r: After e funer	텵	1 ☐Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		injury cocurred	
		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ptace of Inj	ury - At home, farm, stre	eet, factory, office	28f. Location (Street	et and Number or Ru	ral Route Number,
5	ral or a rs after el Dire ed in by	Cert	4 Homicide Section Building, et	э. (Specify)		City or Town,	State)	
	no the nospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best 2 Medical Exeminer: On the basis of and manner street.	of my knowledge, death	occurred at the time, date and place	and due to the caus	se(s) and manner as	stated.
-	vithin 24 h To the Fur	Med	, and mariner ste	ted.				
	Z Z Z S	_	29b. Signature and title of certifier Mr Sn - Pon Houn	emi	29c. License number		. Date signed (Month	
1	1/		30. Name and address of person who completed cause of d	Onth /lto= 22=1/5	031865		5/12/	06
U	0		30. Name and address of person who completed cause of d R	N GW	tam street B	altimore	md 2	120,
	Sta		31. Date filed (Month, Day, Year) 35. Registra	ar's Signature	A. A	-		
	Registra	ar	MAY 1 6 2006	1 SS PROPER				

			1 - For State Registrar	State of M	laryland			t of H	ealth a		ental Hy		e e	96	15405
	Physic	ian	1. Decedent's Name (First, Mid	Row E							2. Date of D	Da	y	Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not instituti	on, give street and number)		4b. City.	Town, or	Location o	of Death	MAY	15		2006 of Death	6:30P M
1	LAGIIII		NORTHWEST	HOSPITAL	CENTE	R	RAN	DALL	5700	لہ لر			BA	LTIM	ORE.
	Funeral Director		5. Social Security Number 215 76 5877 Usual Residence of Decedent	6. Sex 7. A(ge (In yrs. las 4	t birthday) 7 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D. Aug. 1	rth ay, Year) 3,19	958	9. Birthpl Coun Mary	ace (State or Foreign try) Land
	yland		10a. State 10b. Coun	у	10c. City, 1	Town or Lo	ocation	-						10	Od. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ite Mudical Examinat must be notified at	Funeral Director	Maryland Balti	more	E	ssex									1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number	_ 5			10f. Zip		1 2 2 1			10g. Cit		Vhat Coun	try?
	death ms 23	Jera	366 Leeanne Ro	12. Was Decedent		13.	Was Deced		1221 panic Orig	gin? (Spec	cify Yes or No Rican, etc.)	o-	USA 14. Race	A e - America	an Indian,
36	or ite	y Fu	1 Never Married 2 Ma	If Yes Give		1	itYes,spec 1∐ Yes 2		, Mexican, Specify:	, Puerto P	Rican, etc.)			k, White, e	etc.
215-0036	tural.	ed by	3 Widowed 4 Divorce	Year or Dates:	1 1		dent's Usua					10h V	Specify	Wn.	ite
215	hin 72 9. 8n "ne Medic	Completed		est grade completed)		(Give	kind of wor DO NOT us	rk done du se retired)	iring most	of workin	g			siness/Ind	
21	led will lygien her th		12	College (1-4or	,	F	Electr					Nor	thro		umman
Maryland	should be filed withir and Mental Hygiene. s marked other than sumatic event, the Ma	To Be	17. Father's Name (First, Middle Raymond	John Row	6				18. Mother Ade		(First, Middle Kozl			e)	
ary	shoul and Ma s marl umati	F	19a. Informant's Name/Relation			19b. Mailir	ng Address	(Street ar			Route Numb			State, Zip	Code)
Σ	tr. Tag			exwife)		366	Leear	ine R	_	Esse	x Mary				
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.			3 Removal from State	cem	etery, crer	sition (Nam natory or ot	ther place,	4		1te			City or Tov	
altin	permit. Pages Department of Important: If if any injury or o		4 Donation 5 Other (Sain						2006 Izdzins			•	aryland
ä	Depa Impo any i	di l	7-12	772							nue Es				
			23a. P. rt . Enter the disease, c. or heart failure. Lis	or complications that caused tonly one cause on each	d the death. [Do not ent	er the mode	of dying,	such as c	cardiac or	respiratory a	rrest,			Approximate Interval 8etween
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В	Examiner		O		a consequen	ce of):									
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequen	ce of):									
bx.	The law requires that the death certificate be executed the bas been signed by the attending physiclen and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequen	ce of):							_		
8760,	ate be hysicler he buri			d											
9	ertifica ling ph	Physician/Medical	IF FEMALE:			_							_		
Вох	leath certific attending pl	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3	Ectopic pre					2	3d. Date Mon	of deliver	/ Day Year
P.O.	at the de by the a	hysi	1 Yes 2 No 9 Unknown	9 Unknown	t time or deati		(spe								
	igned be det	by	Part II. Other significant condit	_		g in the ur	iderlying ca	use given	in Part I.		23e. Did to	obacco u			cause of death?
Sorc	w require been sig should t	eted	RENAL	FAILURE							-	/es 2[No :	3 🗌 Probal	bly 4 Tunknown
of Vital Records,	The lay ate has page 2	Completed	KENNL	AMILURE	٥				-	_	24a. Was autop perfo	rmed?	pr de	rior to comp eath?	by findings available pletion of cause of
ital		Be C	25. Was case referred to medic examiner?	ul				2	26. Place o	of Death (1 ☐ Yes Check only o	2 No	1 (□Yes 2	□ No
of V	Phys this al dii	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		Outpatient			4 🗀 Nurs		e 5 ☐ Resid				10
O	Attending I ir death. ector: After by the funer	tion	1 Natural 5 ☐ Pend	28a. Date of Inju ng (Month, Da igation	y Year)	b. Time of Injury	M 28	ic. Injury a Work? 1 ☐ Ye	t s 2 ⊟No		d. Describe h	iow injury	occurre	d	
Division	or Attendiafter death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten		ury - At home	, farm, stre	et, factory,	office		28	f. Location (S City or Tow	Street and	Numbe	r or Rural I	Route Number,
	lospital or A hours after uneral Dire														
	T 4 T m	edicai	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the best Examiner: On the basis of and manner sta	rexamination	dge, death and/or inv	occurred a estigation, i	t the time, in my opin	date and ion, death	place, an occurred	d due to the d at the time, d	ause(s) a date and	and man place, ar	ner as stat nd due to ti	ed. ne cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certific	1 1K14 21	CIAN		29c.	License r	number	0.0				(Month, Da	_
	Λ		Han	1				ALC: U	127			NAY		5	2006
			30. Name and address of person	who completed cause of d	eath (Item 23:	a) (Type, F	Print) N	ORT	HWE	E57 1	1705P1	TAL	ง	CE 2	21133 ·
	Sta		31. Date filed (Month, Day, Year	0	ar's Signature	Ann	of s	,01	- UL.	× CO	VICE	0011	<i>x</i>	1-12	グ いクク '
	Registr	ar) I PAW	2000	100	Se Comment of the Com									

			State of Maryland / Department of Health and i	Mental Hy	giene Reg. No.	06	15407
	Physicia	an	1. Decedent's Name (First, Middle, Last) Pennis Ross	2. Date of De Month	eath Day	Yeer	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number), 4b. City, Town, or Location of Deat	IVIAG		006 nty of Death	, 0.,
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. ast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign try)
2	Director		213-70-0383 1 MM 2 F 49 Yrs. Months Days Hours Min.	(Month, Da	9/56		U.M.
	iryland show		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits 1 XYes 2 □ No
	the Ma	Director	MD Baltimore 106. Street and Number 107. Zip Code		10g. Citizen o	of What Coun	
	death with the Maryland ms 23a or 28a-f ahow		2302 Ellamont Street 21216			15A	
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 18. Was Decedent of Hispanic Origin? (S	pecify Yes or No to Rican, etc.)	В	lace - Americ llack, White,	
2-003p	hours after ntural", or ite	ed by	15. Decedent's Education 16a. Decedent's Usual Occupation		Special 16b. Kind of	Business/Inc	ac K
Č	d within 72 giene. rr than "na the Mudic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+)	rking	Local	<u> </u>	1
7 0	Hyg Hyg Sther	a	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle		taura v ame)	11.5
yland	ould be Mental varked o	To B	Winfield H. Ross Jr. Doret		leuto	5N	0.41
Z	ges 1 and 2 should it of Health and Mer If Itam 27 Ia marke or other traumatic		19a. Informant's Name/Relationship (Type, Print Cousin) 19b. Mailing Address (Street and Number or Ri IMrs. Dora Parson 2302 Flamont S	t Bal	TIMO A	m, State, Zip	21216
galtimore,	Pages 1 a nent of He int: If itam iry or othe		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		n - City or To	wn, State (D ₂₁₂₂₄
altin	교투원을 .		4 Donation 5 Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Aurress of Facility	/19/06 F/H	04		/ . \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
n	Depermine Depermine Supplemental Properties of the Supplementa		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial		lende	Batto	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	o o reconstructory c			Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequ⊮nce of):	e e e e e e e e e e e e e e e e e e e			
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1.			
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рох р	death certific e attending p od for use as	ın/Me	IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. I	Date of delive	*
O.		Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
٦.	The law requires that the ste has been signed by th page 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	_			e cause of death?
Sord	v requir been si should		Old traitmetic brain ingu) 10 24a. Was	Yes 2 □ No		ably 4 Unknown psy findings available
Vital Records,	The larete has page 2	Completed		auto		prior to cor death?	npletion of cause of 217 No
VITA	sloian: certific irector.	o Be (examiner?	ath Check only		Other (Specifi	4
Division of	ding Phys th. After this funeral di	-	27. Manner of Death 1 DrNatural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe			//
VISIO	al or Attandit safter death. I Director: Al d in by the fu	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			mber or Rura	l Route Number,
S	is Hospital or Attanding Physician: A24 hours after deals as fure deals as fundared Director: After this certification in the funeral director.		# Homicide Dullaing, etc. (Specify)		wn, State)		
	ha Hosp in 24 ho ha Funa pletely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and my opini	e, and due to the urred at the time.	date and plac	manner as si e, and due to	ated. the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier 29c. License number D 1 5503		1 Date sig	ned (Month,	2006
	BY		Dont un M Moseon MD D 15503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMPTUM M NATEM 50 Dolphin 57 31. Date filed (Monter Play, Year) of 2000 C 32 Registrar's Signaline	Bulton	mos.	2121	7
130	Stá	te	31. Date filed (Month Asy. Year) 6 2006 32 Registrar's Signature			/ /	
	Registr		WILL I O FOOD				

			For State Registrar	State of Marylan		artment of H			ene g. No. 006	15408
78	-	4	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	ı Day Year	3. Time of Death
H	Physici /Medic Examin	al .	Charlott 4a. Facility Name (If not institution, give st		binett		Location of Death	May 10	4c. County of Deat	2:55 Рм
1	Examin	E1	Johns Hopkins Bayy		Ctr.	Balti	more Cit	:y	N/A	
2.40	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		**		nplace (State or Foreign untry)
A	Director		218-36-2389	M 2♥F 68	Yrs.	World's Days	riodis iviii.	Feb. 17		gland
	pur *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Aaryla r sho	ō			,,			2.1		1 ☐ Yes 2X No
	the Marylar 28s-f show	ect	Maryland Bal 10e. Street and Number	timore		10f. Zip Code	Dund		g. Citizen of What Co	untry?
	23a or		8267 Kavanagh Roa	d			1222		United Sta	•
	ter death with the Maryland Items 23a or 28s-f show the must be notified at	Funeral Director		2. Was Decedent Ever in U.	.S. 13.	Was Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race - Ame	rican Indian,
9	or Its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 Tes, specify Cuba 1 □ Yes 2√€ No		o Alcan, etc.)	Black, White	e, etc.
215-0036	72 hours after natural', or ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						White
2-(nett	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done o DO NDT use retired	during most of wor	king 1	6b. Kind of Business/	ndustry
121	within ene. then	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	me.		<i>'</i>		Own	Ueme
d 21	Hygid Hygid ther ant.		11 Years 17. Father's Name (First, Middle, Last)			Homemake		ne (First, Middle, M		nome
an	Aental Aental rked o	To Be	Charles R. Colho	1er			Cha	arlotte R	. Sturn	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than surnatic avant, the M.	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	(îp Code)
	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene Itam 27 is marked other than "natural", or Items 23e or 28e-f show ther traumatic svant, the Medical Examinar must be notified as		Mr. Michael Robin	nette (Son)	826	7 Kavana	gh Road	Dundalk,	Maryland	21222
re,	ss 1 and 2 of Health of itsm 27 i		20a. Method of Disposition	_	Place of Dispo	sition (Name of natory or other place	ce)	Date 2	Oc. Location - City or	Town, State
Ē	Page nent c		1 ☐ Burial 2X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Hi	11top	Service (corp. 5/1	13/2006	rowson, Ma	ryland
Baltimore,	permit. Pages Department of h important: If its any injury or of		21. Signature of Euneral Service License	>	22 D 7	Name and Address uda-Ruck 922 Wise	ss of Facility Funeral Ave. Du	Home of Indalk, Ma	Dundalk, I uryland 21	nc. 1222
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death a cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Atherose	lerat	ic VAS	cular	Diseas	(.	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		- 1113		10.1.0		
	Сханине	_	Sequentially list conditions, b.	Hy Derte	USIR	7				
()	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
(be executed ician and burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					_
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687	tificate ig phys as the		d.							
Box (aath certifical attending phy for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna					23d. Date of deli	very
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Feta 4☐Pregnant at time of d]Ectopic pregnancy] Other (s <i>pecify</i>)			Month	Day Year
P.0	t the de by the tached	hys	9 Unknown	9□ Unknown				12.00		
	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions conf		ulting in the u	nderlying cause giv	en in Part f.		acco use contribute to	
ord	w require been si should a		Dementic					1 🗆 Ye	s 2 No 3 Pr	obably 4 Dunknown
ecc	aw as b	Completed	17-120 ver	ot, lation	Synd	rome		24a. Was an	prior to d	topsy findings available completion of cause of
<u>~</u>		Corr			•			perform 1 □ Yes 2	ed? death?	2 No
/ita	Physicism: Th this certificate al director, pag	Be (25. Was case referred to medical examiner?	-				ath (Check only one		
£	Physic this c	ဥ	I Tes ŠČŽIVO	ospital: 1 Inpatient 2					nce 6 Other (Spec	cify)
n o		ion:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe how	w injury occurred	
isio	tend death tor: the	icat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	omo farm et		Yes 2 □ No	28f Location /Ste	eet and Number or Ru	ural Route Number
Division of Vital Records,	f or Atten after deat Director: I in by the	ertification:	4 Homicide determined	building, etc. (Specif	y)	eet, lactory, office		City or Town		nai Flodie (Valliber,
1	Hospita 24 hours Funeral stely filled	edical Ce	(Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wiedga daat ition and/or in	n occurred at the tic vestigation, in my o	ne date and place pinion, death occu	and duals the eaurred at the time, da	tea(s) and market as te and place, and due	stated to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)
	⊢ s ⊢ ō		I WY X	000		Hon	55900	,	05/11/0	6
	Q		30. Name and ad ress of person who cor	mpleted cause of death (Item	n 23a) (Type.	Print)	, , , , /2		03/11/	
	0		Deburant. Gallo 1	00 do 730 F	10/abis	1 Aveni	u BA11	muc	MI) 21	222
	Sta Registi		31. Date filed (Month Day 1 Year) 200	Begistrar's Signa	ure /	nes)			10. Date signed (Montin 05/11/0 MI) 21	

06-03172 Emil Remeto

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	or Maryland /	-	icate of Dea		intai i iy	_	g. No. 20	06 1540
	ysicia		Decedent's Name (First, Middle, Last	st)					Date of Death Month		3. Time of Death
Medical E	xamı		Emil Remeto 4a. Facility Name (if not institution, given			145.03	T- 1 - 1		Month May 10, 20	006	1930 hrs
			1201 North Tollgate Road			Bel	, Town, or Locatio Air	n of Death		4c. County of D Harford	eatn
	eral		Social Security Number 6. S	ex 7. Age	(In yrs. last				8. Date of Birth		8 irthplace (State or
Dire	ctor		229-16-3173 ₁ ×	M 2□F 8:	2	Yrs. Mon	ths Days Ho	urs Min.	Feb. 16	5, 1924	Country) PA
	any	-	Usual Residence of Decedent 10a. State 10b. County	1.	I.Oc. City. To	wn or Location					10d. Inside City Limits
p	3	L	Md. Harfor		o y ,		Bel Air				1 X Yes 2 No
arylan	or 28a-f show fied at once.	Director	10e. Street and Number			10f. Z	ip Code		10	g. Citizen of What (Country?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Merial Hygiene.	23a or 28a-f sho notified at once.	Ö	1201 N. Tollgat	e Road			21014			U.S.A.	
ith with	tems 2	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces?	ver in U.S	13. Was Dece If Yes, spe	dent of Hispanic (cify Cuban, Mexic	origin? (Spe an, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ar White, et	merican Indian, 8lack, c.
ter dez	", or i				No	1 Yes	2 No spec	fv.		Specify:	white
ours af	ntural	å Š	15. Decedent's Education (Specify o	or Dates:	oleted) 16	a. Decedent's Usu	al Occupation (Gi	ve kind of wo		16b. Kind of 8usine	ess/Industry
6 ո 72 հ	an "n; ical Ex	efe	Elementary/Secondary (0-12)	College (1-4 or 5-	+)		orking life. DO No	OT use retire	ed)		
.003 within	her th	Completed	8 years 17. Father's Name (First, Middle, Last			assemble		orla Noma /	First Middle M	automoti	ve
21215-0036 buld be filed within 7 Mental Hygiene.	ked ot nt, th	BeC	George Remeto	,					Katusin	aideir Surrianie)	
21: ould b	s mar	2	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing Addre	ss (Street and N	umber or Ru	ıral Route Numb	per, City or Town, S	tate, Zip Code)
MD hd 2 sho alth and	n 27 i	1	Rick Remeto/son		1201 51					ir, MD 21	
Baltimore, permit. Pages 1 ar Department of He	tant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner		1 X Burial 2 Cremation 3	Removal from Stat	e cren	e of Disposition (N natory or other place	e)		Date	20c. Location - City	
Itim it. Pag rtment	y or o		4 Donation 5 Other Specify 2 Signature of Funeral Service Licer		High	view Mem			3/2006	Fallsto:	n, Md.
Baltimore, MD 2 permit. Pages 1 and 2 shour Department of Health and N	II.		No Carrio	Cana De	2.0	Schi	d Address of Fac nunek Fu	neral	Home_of	Bel Air	, Inc.
Physic		T	23a. Part I. Enter the disease, or comp failure. List only one cause on e	olications that caused the	ne death. Do	not enter the mode	MacPh e of dying, such a	a i L Ro s cardiac or i	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Med Exam	_	1	Immediate Cause (Final disease a.	Head Injuries							Death
			or condition resulting in death) Sequentially list conditions b.	Due to (or as a consec	quence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence of):						
		Examiner	(Diesass or injury that Initiated events resulting in death) Last	Due to (or as a consec	quence of):						
ecuted	and transi		d.								
Records, P.O. Box 68760, The law requires that the death certificate be executed	physician and the burial - transit	Medical	UNPENDED	AMENDED					_		
8760, tificate be	ng phy as the l		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	e of pregnan	cy ₂ Fetal deat	n 3 Ecto	pic pregnan	cy	23d. Date of deli Month	very Day Year
Box 68'	e attending I for use as t	Physician	1 Yes 2 No 9 Unknown	4 Pregnant at ti	me of death	5 Other (Sp		, , ,			ŕ
the de	by the	Ph	Part II. Other significant conditions	9 UINIOWII	 but not resul	ting in the underlyi	no cause given in	Part I	23e. Did tob	acco use contribute	to the cause of death?
P.C	certificate has been signed by the ector, page 2 should be detached f	d b	COPD; HTN; Prostate Ca						1 Yes	2 🗸 No 3 📗 F	Probably 4 Unknown
rds requi	should	Completed by							24a. Was au		autopsy findings available to completion of cause of
ecc The lav	ate ha	dwo					_		perform	ned? death	1?
iai F	certific	Be	25. Was case referred to medical examiner?	1			26.Place of Dea		nly one)		
f Vir	After this certificate I	리	1 ✓ Yes 2 No 27. Manner of Death	lospital: 1 Inpatien		/Outpatient 3 b. Time of Injury	DOA Other			desidence 6 🗸 0	ther: Scene
Division of Vital Records, P.O tal or Attending Physician: The law requires that trs after death.	r: Aft	Certification:	1 Natural 5 Pending	May 7, 2006	ar) 19	920 hrs	1 Yes 2	_ Is	ubject fell d		
ivisio I or Atte after des	reral Director: filled in by the	fica	2 Accident Investigat 3 Suicide 6 Could not	28e Place of Inju	ry - At home	, farm, street, facto	y, office building,	etc. 2			Rural Route Number, City
Di Hospital 24 hours at	filled	Cert	4 Homicide determine		le Family	Home		1:	or Town, Sta 201 North T	^{ate)} ollgate Road, I	Bel Air, MD
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: completely filled in by the		29a Certifier 1 Certifying Physic one 2 Medical Examine	an: To the best of my							
To the	Com	Medical	296. Signature and title of certifier	and manner stated			9c. License numb			29d. Date signed (
,			()/ Rhu ka	low!			O.C.M.E.			May 11, 2006	
1)	<		30. Name and address of person who								
5		ate		ant Medical Exar		11 Penn Stree	t, Baltimore,	MD 2120	1		
		7.7	 Date filed (Month, Day, Year) 	32. Regietrar's	solanature						1

DHMH 17 Rev 1/2001 OCME 2006

	1	State of Maryland / Dep			ne 2006	5 - 0
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Lonetta R. Rohm 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	2. Date of Death	Day Year 2006 4c. County of Death N/A	3. Time of Death
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 91 Yrs. Usual Residence of Decedent		8. Date of Birth (Month, Day, Yei March 13,	9. Birthpl	ace (State or Foreign try) Land
with the Maryland a or 28a-f ehow be notified at	ector	10a. State10b. County10c. City, Town orMarylandBaltimore	Location Middle River 101. Zip Code	100	Citizen of What Coun	Od. Inside City Limits 1 ☐ Yes 2 💆 No
er death Iteme 23	Funeral Director	10e. Street and Number 9804 Jonathan Cowrt 11. Marital Status 1 □ Never Married 2 □ Married 11 □ Never Married 2 □ Married 11 □ Never Married 2 □ Married 11 □ Never Married 2 □ Married 12 □ Never Married 2 □ Married 13 □ Never Married 2 □ Married 14 □ Never Married 2 □ Married 15 □ Never Married 2 □ Married	21220 B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		U.S.A. 14 Race - America	an Indian, etc.
within 72 hours aft ene. then "natural", or	Completed by	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-407.5+)	1 ☐ Yes 2X No Specify: redent's Usual Occupation re kind of work done during most of work DO NOT use retired)	rking 16b	. Kind of Business/Inc	·
d 2 should be filed within 72 h d 2 should be filed within 72 h d and Mental Hygiene. 7 is marked other then "natu traumatic event, II a Modical	To Be Con	17. Father's Name (First, Middle, Last) Henry J. Dauer	Reg		eg	
of Health and I frem 27 Is ma		Mrs. Jenniser Moss (daughter) 980	iling Address (Street and Number or Ru 4 Jonathan Cowrt, position (Name of rematory or other place)	Middle Riv	Location - City or To	1220 wn, State
permit. Pages 1 and 2 Department of Health Important: if Item 27 any injury or other tr		4 □ Donation 5 □ Other (Specify) Most Hold 21. Signature of Funeral Service Licensee	22. Name and Address of Facility Se 9705 Belain Rd., I	Saltimore,	uneral Hom MD 21236	es
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nter the mode of dying, such as cardiac	c or respiratory arrest,		Approximate Interval Between Onset and Death
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ath certificate be extending physicien for use as the buria	Physician/Medicai		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
uires that the de signed by the a	by	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobaci 1 ☐ Yes	co use contribute to the	ne cause of death?
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Anatural 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	Other: 4 Nursing Page 1 Nursing Page 1 Nursing Page 2 Nursing Page	ath Check only one) Home 5 Residence 28d. Describe how in the control of the co		
Hospital or A 4 hours after Funeral Directely filled in by	edicai Certif	4 Homicide determined building, etc. (Specify) 29a. Certifier (Check only 2 Hedical Examiner: On the basis of examination and/or	eath occurred at the time, date and place	City or Town, S	State) Se(s) and manner as s	tated.
To the To the comple	Med	29b. Signature and title of certifier	29c. License number D 5324		Date signed (Month,	
5 St	ate		spirtal 900 Cati	n Avenue	Baltimor	e MD 21229
DHMH 17 Rev 1/2		MAI T O TONO DENTIL				

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	-	epartment of Certificate of		Mental Hy	giene () ()6	15411
			Decedent's Name (First, Middle,	Last)				2. Date of D		Year,	3. Time of Death
	Physici /Medic		GEORGE	W	ROHL	EDER	+	May	ia a	006	5:30 AM
	Examir Funeral	. (C C * **		Ge Hospit	al Centre (In yrs. last birt	hday) If Under 1 Yea		8. Date of B	rth av, Year)	of Peath 1 1 9. Birth	MOR place (State or Foreign
	Director	100	220 07 2919 Usuel Residence of Decedent	1 Ճ M 2□F	88	frs.	7,0013	AUG 9	, 1917		RÝLAND
	yland		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
(0	ath with the Marylan 23a or 28a-f show	ctor	,	ALTIMORE			MIDDLE R	IVER			1 Tyes 2 No
8	with the	Dire	10e. Street and Number	OAD AP'	г. 1A	10f. Zip Code	21220		10g. Citizen of V		intry? S.A.
b a	death ms 23	Funeral Director	201 MIDDLEWAY Ro	12. Was Decedent B		13. Was Decedent of ff Yes, specify Cu		pecify Yes or N	o- 14. Rac	e - Amen	ican Indian,
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or Items 23a or 28a-f show na Medical Exe of per most be notified at	Completed by Fur	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 Arma If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	o Specify:	to Hican, etc.)	Spec	k, White, HITI	E
75	in 72 h	ojete	15. Decedent's (Specify only highest	grade completed)		Decedent's Usual Occu (Give kind of work doni life. DO NOT use retir	e during most of wor	rking	16b. Kind of Bu		•
05		dmo	Elementary/Secondary (0-12)	Callege (1-4or 5	+)	TRANS &T	•	SIGNS	BALTI	MORI	E CITY
OF THE PERSON NAMED IN COLUMN TO PERSON NAME	ould be filed Mental Hygi arkad other atic event, it	To Be C	17. Father's Name (First, Middle, La		LEDER		18. Mother's Nar	•	JNK .	e)	
Aan	and and le m		19a. Informant's Name/Refationship		1	Mailing Address (Stree					
ركي في	1 and 2 Health tem 27		MICHAEL G. RC 20a. Method of Disposition	HLEDER/SO	20b. Place of	900 BRICK Disposition (Name of		AD POTO	DMAC, MD 20c. Location -		
altimor	9 0 - 2		1 Burial 2000 remation 3 4 Donation 5 Other (Spe		METRO	CREMATOR	(\mathbf{Y}^{0}) 5/15	5/06	BALTIM	ORE	, MD
Balti	permit. Pag Department Importent: I any injury c		21. Signature of Fureral Service Li	censee		22. Name and Add 1211 CHE					NERAL HOME 21237
			23a. Part 1. Enter the disease, or conshock, or heart failure. List or	omplications that caused by one cause on each lin	the death. Do no.	ot enter the mode of dy	ying, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Pheu	moru	a					
	Examiner			Due to (or as:	a consequence of	or):					
	De sit	lner	Sequentially list conditions, I any leading to an induction cause. Enter Underlying Cause (Disease or injury	Due to or as	a consacuence o	of]·					
_6	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence (of):				-	
8760,	cate be e chysiciar the buri	by Physician/Medical E		d						-	
9	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Dat	e of defiv	verv
Box	death	siciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Mo		Day Year
P.O.	that the de ed by the a detached	Phys	9 ☐ Unknown Part fl. Other significant condition		ut not societing in	the underhine enues	augo in Part I	23a Did	tobacco uso contr	abuta to	the cause of death?
ds,	uires tha		Part II. Other significant condition	s continuuting to death bi	at not resulting in	i the underlying cause g	gwen in Part I.		Yes 2 No	3 Pro	
S	aw requir as been si 2 should	Completed						24a. Wa	s an 24b. \	Vere aut	opsy findings available ompletion of cause of
- Re	The lavate has	Som						auto perl 1 Yes	ormeg? c	leath?	2 No
Vita	ician; The certificate ha rector, page	Be	25. Was case referred to medical examiner?	Hospital:		10	26. Place of Dea				
jo	g Phys ler this neral dii	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injud (Month, Date		ime of 28c. Inj	4 🗆 Nursing F	T	how injury occurr		fy)
ion	ittending I death. ctor: After y the funer	ation	1 Natural 5 ☐ Pending investiga	tion	/ Year) II		ork? ⊒Yes 2 □No				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of fnite building, etc	ury - At home, fa c. (Specify)	rm, street, factory, office	в	28f. Location City or To	(Street and Numb own, State)	er or Rur	al Route Number,
	Hospi 24 hour Funer stely fill	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of caminer: On the basis of and manner sta	examination an	, death occurred at the d/or investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	cause(s) and ma , date and place, a	nner as s	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and marries ste		29c. Licer	nse number		29d. Date signed	1 (Month,	Day, Year)
	1			7-1		7	263211	6	May 1	2,	2006
	1		30. Name and address of person w	no completed cause of d	eath (Item 23a)	Type, Print)	VONO A	ntimo	a mr	21	120
5	Sta	ate	31. Date (ijed (Month, Day, Year)	32. Registra	ar's Signature	111 Symie 1	UNIVE &	MIIII	14, 1111	all	7.01
. 3	Regist	rar	MAY 1 6 2006	fe -	1 ho	di					
Dł	HMH 17 Rev 1/2	001		Jesus)	19	ICINIAL					
					OH	IGINAL					

				Type or Print in 1,855,5/16/06 TI State of Maryla		delible Ink. Ensure a	All Copie: Mental Hy	s Are Leg	ible. 106 15	412
			State Registrar		Ce	rtificate of Death		Reg. No.		
	Dhyoici	20	1. Decedent's Name (First, Middle, Las				2. Date of D	eath Day	Year 3. Time	of Death
	Physicia /Medic		HATTIE EDNA!	Robinson			MAY	10 7 0	06 2.	30 AM
	Examin	er	4a. Facility Name (If not institution, give MARINER FURNISHED)	E BRANCH &	D -	4b. City, Town, or Location of Dea		ANNE	ty of Death EARUNE	EL
	Funeral Director		VI2 YO 10201	7. Age (In yrs	. last birthday, Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		irth 1925 Pay, Year)	9. Birthplace (State Country)	+ND
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Q	ity, Town or L	ocation			10d. Inside	City Limits
	death with the Maryland ims 23a or 28a-f ahow r mest be notified at	ō	MD AME A	a said	ACAT	SENIA			1 □ Y∈	as 2 No
	288	Director	10e. Street and Number			10f. Zip Code		10g. Citizen o	f What Country?	
	n with	0	221 DUNKAP	RD.		21122		U	·5-A.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in Amed Forces?	U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or N	lo- 14. Ra	ace - American Indian, ack, White, etc.	
036	I within 72 hours after death with the Marylan jiene Itan "natural", or tiems 23a or 28a-f ahow Ita Medical Enami me mast be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:	no mount die.	Spec	1 *	5
2-0	72 ho	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	edent's Usual Occupation a kind of work done during most of w	orking	16b. Kind of	Business/Industry	
Maryland 21215-0036	i filed within I Hygiene. other than "rent, I'm wer	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Fig.	DO NOT use retired) DREMAN		BA	KERY	
land	o d is b	o Be (17. Father's Name (First, Middle, Last)	Inison		18. Mother's Na MAQ 7	ime (First, Middle	e, Maiden Suma	ame)	
ary	shound N	-	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street and Number or F	Rural Route Num	ber, City or Tow	n, State, Zip Code)	
Ž	1 and 2 s Health ar sem 27 is		TONI ROYSTON F	RIEND	26	DUNIAP RO PASA	DENA	UD. 21	122	
ře,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition		Place of Disp cemetery, cre	osition (Name of matory or other place)	Date	20c. Location	- City or Town, State	
Baltimore			1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		ATDMY (GIFTS REGISTEN 5-	15-06	HAND	VER MI	•
alt	permit. Pag Department Important: I any injury o		21. Signatur of Funeral Service Licer			Name and A Tress of Facility Doughorty Family Funeral	Homo And Cr	motion Conta	a DA	
_	Dep den gang		14. N. S	wind	>	Daugherty Family Funeral 2601 Mountain Roa	d - Pasadena	MD. 21122		
			23a. Rant. Enter the disease, or con shock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not en	iter the mode of dying, such as cardi	ac or respiratory	arrest,	Approxim Interval B Onset an	Between
纒	Physician		Immediate Cause (Final disease or condition	a Conge	stiv	e Heart fa	lino		2 12	poles
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	1: 1		1	2-5	7
1		_	Sequentially list conditions,	Due to (or as a conse	My y	Ocardial -	Lin far	clon	2 w	eells
V	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	11-11-0	tous	^ ^			130 U	0 00 1
	executed an and rial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):	1*\			30 9	NO C
200	- (0 -			d						
9289	ufficat g phy as th	edi								
O. Box	The law requires that the death certificate be the has been signed by the attending physicionage 2 should be datached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			Date of delivery Month Day	Year
Δ.	that the de led by the detached	Ph	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying cause given in Part I.	23e. Dio	tobacco use co	ntribute to the cause o	f death?
Records,	sign sign d be	d by					1+2	Yes 2□No	3 ☐ Probably 4 [∐Unknown
Sor	w require been signal	Completed					24a. Wa	s an 24h	. Were autopsy finding	ns available
Re	The lav	E D					aut per	opsy formed?	prior to completion of death?	cause of
Vital		e Cc	25. Was case referred medical			26 Place of P	ath (Check only		1 Yes 2 No	
>		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	Othor	Home 5 ☐ Re		ther (Specify)	
ı of	g Physer this neral di		27. Mann 1 Death	28a. Date of Injury (Month, Day Year)	28b. Time o			how injury occi		
<u>ö</u>	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigatio	1	Mary	M 1 Yes 2 No				
Division	2 # 6	Certification:	3 Suicide 6 Could not be determined		home, farm, s	treet, factory, office		(Street and Nur own, State)	nber or Rural Route No	ımber,
	To the Hospital or within 24 hours after To the Funeral Dirto completely filled in					th occurred at the time, date and place				e(s)
	the H nin 24 the F the F	Medical	one)	and manner stated.						
	Valt To Com	2	29b. Signature and title of certifier	braces N n		29c. License number		29a. Date sign	ned (Month, Day, Year)	J
			Provin J. Ran	and u.D		1) 26-207	100	2/12	-106.	
	in		30. Name and address of person who	completed cause of death (It		2 W. MAPLER	0. 21	VTHIC	UM MD 2	1090
	1	110	31 Date filed (Month Day Year)	32 degistrar's Sio		4	-, -, ()1 110 -	, , , ,
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 6 2	32 Registrar's Sig	N. A.	and				

Please Type or Print in Black Indelible Ink

Charles Schraude	-		•	nent of		Mental H		La II	20	106 151
Physicia	_	eqistrar . Decedent's Name (First, Middle,Last)	Certin	- Cate or	Douth		2. Date of De	Reg No eath	in U	3 Time of Death
Medical Examin	-	Charles Schrauder, III					Month May 7, 2	006 Day	Year	1425 hrs
The state of the s		ta. Facility Name (if not institution, give street and number) southbound 1-95 on-ramp at Kane Street		4	b. City, Town, or L Baltimore	ocation of Death		4c.	County of Dea	ath
Funeral	4	·	yrs. last b	irthday)	If Under 1 Year	If Under 24Hrs	8. Date of E	Birth (MM/E	DD/YYYYY 9. E	Birthplace (State or
Director			23	Yrs.	Months Days	Hours Min	_	/1982	Fore	
	ŀ	214-08-6917 1 XM 2 F 2	23		<u> </u>	<u> </u>	0/1/	7 1 302	<u>- </u>	
* any		10a. State 10b. County 10c	c. City, Tow	n or Location	on					10d Inside City Limits 1 Yes 2 XNo
/land -f shov	ğ		Essex		10f. Zip Code	_		10a Citiz	en of What Co	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number			·			0		iditi y :
with th		759 Seawall Road 1. Marital Status 12. Was Decedent Eve	er in U.S.	13. Was	21221 Decedent of Hisp	panic Origin? (S	pecify Yes or N		S. A. 14. Race - Ame	erican Indian, Black,
death v	Funeral	1 Never Married 2 Married Armed Forces?	No	lf Y€	es, specify Cuban,	Mexican, Puerto	Rican, etc.)		White, etc.	
after after al", o	ᇑ	3 Widowed 4 Divorced If Yes, Give Year or Dates:			Yes 2X No					nite
hours "natu		15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)	ted) 162		's Usual Occupationst of working life.			16b. K	ind of Business	s/industry
36 thin 72 te. than	Completed	10	Т.	abore	r			CO	nstruct	-ion
5-0036 iled within 77 Hygiene. I other than the Medical		17. Father's Name (First, Middle, Last)		<u>unorc</u>		8 Mother's Name	(First, Middle			
2121 ould be fil Mental H marked	8	Charles Schrauder, Jr. 19a. Informant's Name/Relationship (Type, Print)		Oh Mailian	Address (Street	Juditl			Town Cha	-t- 7:- Code)
MD 2 Id 2 shoul lith and N n 27 is m aumatic	ျ	Charles Schrauder, Jr.	100		eawall R				nd 2122	
	-	20a. Method of Disposition	20b. Place		tion (Name of cerr	netery,	Date			or Town, State
Baltimore, permit Pages I a Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:		•	rematory	20	/10 006	Bai	ltimore	e, Maryland
altir	Ì	21 Signature of Funeral Service Licensee		22. N	ame and Address	of Facility	al Home	PΔ		
	-	23a. Part I. Enter the disease, or complications that caused the	doodb Do	1 14	от ота Е	astern A	4venue	ESS	ex, Mar	ryland 21221 Approximate Interval
Physician /Medical		failure List only one cause on each line.			le mode of dying, :	sucri as cardiac (л гезрігаюту а	irrest, sriot	JK, OF Healt	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Narcotic into		ion						
		Sequentially list conditions, b.								
	aminer	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause	ence of):							
ed isit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	ence of):		-					
execuin and	edical	X UNPENDED AMENDED item#	# 23a,2	27,28a-	f,perME,g8	5,5/18/06	TT		•	
760, cate be or physicia		IF FEMALE: 23c. If yes, outcome of the stat	of pregnance	су					. Date of delive	
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy uneral director, page 2 should be detached for use as the burneral director, page 2 should be detached for use as the burneral director.	Physician/M	past 12 months? 1 Live birth Pregnant at time	e of death		al death 3 (Ectopic pregn	ancy		Month	Day Year
Box e death c	nysi,	1 Yes 2 No 9 Unknown 9 Unknown		Ou	iei (opealy)					
.O. hat the ed by t	by P	Part II. Other significant conditions contributing to death bu	it not result	ting in the u	nderlying cause g	iven in Part I.		_	_	to the cause of death?
S, P. quires the signer							24a. Wa			autopsy findings available
ord aw rec nas bee	Completed						aut	opsy formed?		o completion of cause of
	녌				00 D	-10-11-101-1	1 🗸 Yes	2 No	1 🗸	Yes 2 No
ital sician: s certi	Be	25. Was case referred to medical examiner?	2 FR	/Outpatient		of Death (Check Other Nursi	ng Home 5	Resider	nce 6 🗸 Oth	ner: Scene
sion of Vital Records, Attending Physician: The law requir r death. ector: After this certificate has been s by the funeral director, page 2 should b	P.	1 ✓ Yes 2 No Imparent 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28	b. Time of I		y at Work?	28d Describ		L	
	ij	Natural 5 Pending Pending Fnd 5/7/200		nd 2:15	PM 1□Y	es 2 X No	unk			
Division nal or Attendin as after death. "at Director: A	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury		, farm, stree	et, factory, office be	uilding, etc.	28f. Location or Town	(Street S	nd Number or I	Rural Route Number, City on ramp
E 8 E	ခြ	4 Homicide determined (Specify) Road					at Kane	Stree	t, Balti	more, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examiner								
To with	Me	29b. Signature and title of certifier		-	29c. License	number		29d. [)ate signed (A	Month, Day, Year)
1 2		(lucx2			O.C.1	И.Е. 		May	8, 2006	
Sola	_	30. Name and address of person who completed cause of death Ana Rubio MD. Assistant Medical Examine			treet, Baltimo	re, MD 2120	1			
	ate	31. Date filed (Month Pay Year) 6 2006 32. Registrar's 3	Signature		ortin					
Regist	rar		. On . March	4						

			1 - For State Registrar	State of Maryland		rtment of H			ene 200	6 15414
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Robert Le		h, Jr	•		2. Date of Death May 10,	2006 Year	3. Time of Death 7:30 AM
er.	Examin		4a. Facility Name (If not institution, give s Bradford Oaks N 5. Social Security Number 6. Sex	ursing Home	ıst birthdav)	4b. City, Town, or Clinton	Location of Deat	8 Date of Birth	9 Bi	George's
	Funeral Director		Usual Residence of Decedent	3¥ 2□F 73	Yrs.	Months Days	Hours Min.	Sept 26	<i>Year)</i> C	ryland
	h the Marylar or 28a-f ehow or colling at	Director	10a. State 10b. County Maryland Prince Ge 10e. Street and Number		Town or Lo			10	g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2☐ No XX
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28e-f ehow event, it a Medical Examinar must be notified at	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1	207 Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	United Sta 14. Race - Am Black, Whi	erican Indian, ite, etc.
Maryland 21215-0036	within 72 hours ene. then "natural"; ne Medical Ex	Completed by	3 ☐ Widowed ▼ Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L	lent's Usual Dccupa kind of work done d DO NOT use retired)	uring most of wor	rking 1	6b. Kind of Business Self Er	
yland 2	should be filed v ind Mental Hygie s marked other t umatic event, IL	To Be Co	11 17. Father's Name (First, Middle, Last) Robert Lee Smith		Plum	bei		ne (First, Middle, M Virginia	aiden Sumame)	nproyed
	and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationship (Tyr Bryan Smith (Broth 20a. Method of Disposition 1 XX Murial 2 □ Cremation 3 □ R	ner)	3724 ace of Dispo	,	keland l	Orive, Me	City or Town, State, Chanicsvil Oc. Location · City or	lle, MD 20659
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Ced	, 22	. Name and Addres	s of Facility Lee			6633 01d
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	ence of):	or the mode of dying	g, such as cardiac	T	st,	Approximate Interval Between Onset and Death
O. Box 68760,	It the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	ncy death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
ص	signed be de	by	Part II. Dther significant conditions con	ntributing to death but not resu	lting in the ur	nderlying cause give	n in Part I.	23e. Did tob		to the cause of death?
of Vital Records	The law ete has b page 2 s	Completed	OF West and stated to medical						ed? prior to death?	utopsy findings available completion of cause of s
	Attending Physician: 1 r death. ector: After this certificel by the funeral director, p	ertification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	7	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: Nursing H	ath (Check only one lome 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
Division	putal or ours afte naral Dir filled in i	O	3 Suicide 6 Could not be determined	28e. Place of Injury · At hor building, etc. (Specify, sician: To the best of my know)		e date and place	City or Town,		
	To the Hos within 24 hr To the Fun completely	Medical	(Check only one) 2 Medical Exami-	ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my op	number	rred at the time, da	d. Date signed (Mon	e to the cause(s)
7	4	Ä	30 Nerdo and address of place who co	empleted cause of death (Item.	(23a) (Type,	Print)	U#10	3 FT. W.	3/1406	1020149
4	Sta Registi		31. Date tiled (Month, Day, Year) MAY 1 6 20	32 Aegistrar's Signate	ure	and i				

Amend item#17,perFH,ge35,5/16/06 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No:-2 Date of Death 1. Decedent's Name (First, Middle, Last, Year **Physician** Sheppard 2006 tuderson am /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Drince Geor Community annam Doctors If Under 1 Year | If Under 24 Hrs. 5. Social Security Number yrs. last birthday) **Funeral** Days Hours 215.18.0176 1 MM 2 ☐ F 87 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a or 28a-1 ahov ury or other traumatic avent, the Madical Examinar market be multiled at DC Washington 1 XYes 2 □ No Director 10e. Street and Number er. Zip Code 10g. Citizen of What Country? 1301 Adams Street N.E. 20018 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lementary/Secondary (0-12) College (1-4or 5+) Home Improvement Painter 9th grade 17. Father Name (First, Middle, Last) Sheppard 18. Mother's Name (First, Middle, Maiden Sumame) Willis Junies Magale 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zio Codel permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Dorothy Saunders/ Apt # 805 Balto MD 21211 Sister 3700 Greensonina 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Rurial 2 Cremation 3 Removal from State Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Funeral Sewices 105 York Road Baltimore MD 21212 21. Signature of Funeral Service Licensee M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury Que to for as a consequence of ysician and le burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Physician/Medical the use as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 1 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € 100 1 Impatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No death. Director: , 6 Could not be 3 🗌 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 \(\text{Homicide} \) ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058290 MD 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESHKUMAR QUEENSBURY RD. HYATTSVILLE, MJ 20181 MUTTATH 4203 32. Registrar's Signatur 31. Date filed (Month, Day, Year) MAY 1 State 6 2006 Registrar

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-	Examin	er		Chesapea	. •			r	40. Oily		1 Ai			10.00	Harfo		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY 1^{Day} 2006 Physician 7:05P SACHA JOSEPH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 2024 SUE CREEK DRIVE If Under 1 Year | If Under 24 Hrs. | 8. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5 Social Security Number 6 Sax **Funeral** Months Days Hours MARYLAND 1**X** M 2 □ F 83 214-14-8928 12-12-1922 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ XNo MIDDLE RIVER BALTIMORE MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 U.S.A. 238 117 RODEO CIRCLE death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Internatively internatively from the marked other then "natural", or iter important: if Item 27 is marked other then "natural", or iteratively injury or other traumatic event, the Medical Examinations. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 □Widowed 4 □ Divorced Year or Dates: 1943-46 WHTTE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY POLICE OFFICER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARGARET (OTENASEK) JOSEPH SACHA ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ESSEX, MD 2024 SUE CREEK DRIVE MARY SCHAEFER/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 5-18-2006 BALTIMORE, HOLY REDEEMER CEM. MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee ROSEDALE, MD 21237 1211 CHESACO AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ladder Can Cer **Physician** ga disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown signed by the 23e. Did tobacce use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 √s 2 No 3 Probably 4 Unknown been si Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b lirector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) DIWNEYS ို 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manne of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical 🗫 aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) and title Signature 29b. of certify

State Registrar

31. Date filed (Month,

N. Charles St. #5105 6701 32. Registrar's Signature

			State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa Registrar		lental Hygi	_	15418
	* 1860 g		Decedent's Name (First, Middle, Last)		2. Date of Death	1 2	3. Time of Death
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	Examir	46	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
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	Funeral Director		216–26–7905	Months Days Hours Min.	8. Date of Birth (Month, Day, July 1.		llace (State or Foreign htry) ['n_
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Maryland 21215_0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f ehov any njury or other treumatic event, its modified at any njury or other treumatic event, its modified at any of the profile of the pr	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of work IO NOT use retired)	ing	16b. Kind of Business/In	dustry
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Mr. Baltimore	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowric	atory or other place) May	16, 2006	20c. Location - City or To 5 Elkridge	
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a s s	Physician /Medical		23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or learn failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	- 1	or respiratory arre	ost,	Approximate interval Between Onset and Death
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Division of Vital Becords	The law requires that the ste has been signed by the bage 2 should be detache	Completed	ASSESTOSIS Chronic Obstructive pulmor	navy disease	24a. Was ar autops perform 1 Yes 2	24b. Were auto prior to co death?	psy findings available mpletion of cause of
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	To the Yithin To the Complex C	Me	29b. Signature and title of certifier	29c. License number	25	d. Date signed (Month,	Day, Year)
			blobert of moraces, MD	D006997		05/15/20	06
	0)		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)			
9	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 6 2006 32. Registrar's Signator				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 58M PURLING **Physician** CLAUDETTE 2806 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTION S PHNONUSZEWA CENTON TAL NERTHWES 458 M If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month Days | Hours | Min. | 4. Month Day 7. Age (In yrs. last birthday). 9. Birthplace Country) (State or Foreign 5. Social Security Number 6. Sex **Funeral** 212-32-9177 1 M 2 KF Director Usual Residence of Decedent 10h County 10c. City Town or Location 10d. Inside City Limits 10a State r than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 21133 Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQN/05T use ratical) 16b. Kind of Business/Industry 15. Decedent's Education fy only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) erK other Mother's Name (First, Middle, Maiden Sumame) Father's Name (Nirst, Middle, Last) nt of Health and Mental H I: If item 27 le marked ott / or other traumatic even Be Pages 1 and 2 should be nent of Health and Mental annie Terr arson ber or Rara Route Number, City or Town, State, Zip Code) (Type, Print) 19b. Mailing Adress (Street and N 9a Informant's Na ma/Relatio allstown 20b Rlace of Disposition Name of Date 20c. Location - City or Town, State Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Depertment important: If eny injury o 5-20-06 Ordlawn lood lawn 21. Signature of Funeral Service Licens Services elutorun, ma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CASDONIE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner or Attanding Physicion: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ CHRONIE 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Cothonep A Total 24a. Was an autopsy performed? (es 2 (1) No DABETIE this certificate willita 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 100 1 Depatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ů, 29d. Date signed (Month, Day, Year) 29c. Liçense number 29b. Signature and title of certifie 18502 2886 MAG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CON TEN2 HESPITAL

DHMH 17 Rev 1/2001

State Registrar ORKHNOO

31. Date filed (Month, Day, Year)

6 2006

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RANDALLSTOWN

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CONANAN MED

32/Registrar's Signature

Dust	Y	M. Shuck	a an Drint	in Dinak Indalihia i				
JNK		State aryland / D	Departmen				000	~ t = 1 ~
Physicia	لــــــــــــــــــــــــــــــــــــــ	I- For State Registrar 1. Decedent's Name (First, Middle,Last)	Certificate	e of Death	2. Date of D	Reg. No eath	200	3. Time of Death
cal Examir		DUSTY MYRIAH SHUCK			Month May 4, 2		Year	0600 hrs
		4a. Facility Name (if not institution, give street and number) I 70, Mile Marker 67		4b. City, Town, or Location of Mount Airy	f Death		County of Death rederick	ו
Funeral Director			ln yrs. last birthda	Months Days Hours	Min.		DD/YYYY) 9 Bir Foreig	gn
	ŀ	Usual Residence of Decedent		Yrs.	Dec.	29,	1981 00	Odifioi
ow any		10a. State 10b. County 10 New Mexico Grant	c. City, Town or L Silver					10d Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	9 L	10e. Street and Number	DIIVEI	10f. Zip Code		10g. Citiz	zen of What Cou	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland neur of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		53 Rafter D Drive		88061			U.S.A.	
items 2	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?		 Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican, 		No-	14. Race - Amer White, etc.	ican Indian, Black,
after de	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No specify			Specify Wh	ite
led within 72 hours afte Hygiene. other than "natural", th. Medical Examiner	ted k	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)		edent's Usual Occupation (Give k ng most of working life. DO NOT ι		16b. K	(ind of Business/	Industry
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be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)	•		s Name (First, Middle		,	
ould be fil Mental F marked ic event, t	o Be	Danny Shuck 19a. Informant's Name/Relationship (Type, Print)	19b. M	Lori lailing Address (Street and Numl		reutz lumber, Ci		e, Zip Code)
is I and 2 should be fi of Health and Mental If item 27 is marked		Lori Kreutzer-Atwood (moth		40 Hwy 180 E #2				
ages 1 an nt of Hea nt: If iter		20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State	crematory	isposition (Name of cemetery, or other place)	Date		Location - City or	New
permit Pages I av Department of He Important: If ite	ļ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Memory	Lane Cemetery 22 Name and Address of Facility	May 16, 2	20 0 6 S	Silver (City, Mexico
perm Depa Impo		George & Ferrance		22 Name and Address of Facility Mitchell-Wiede: 6500 York Road	u Dartilli	ore.	Mar vian	c. d 21212
hysician Wedical		23a. Part I. Effer the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not er	nter the mode of dying, such as ca	ardiac or respiratory	arrest, sho	ock, or heart	Approximate Interva Between Onset and
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death) a Sharp And Blunt F Due to (or as a consequence)						Death
		Sequentially list conditions, b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ience of):					
ted d ansit		events resulting in death) Last Due to (or as a consequence)	uence of):					
icate be executed physician and the burial - transi	sician/Medical	UNPENDED AMENDED						
ficate b g physicate but the but	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	of pregnancy	Fetal death 3 Ectopic	pregnancy		d. Date of deliver	y Day Year
eath certific attending providers as the	iciar	past 12 months? 4 Pregnant at tim	ne of death 5	Fetal death 3 Ectopic Other (Specify)	pregnancy	- (WORTH	Day feal
that the deared by the are detached for	Phys	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause given in Pa	rt 1 23e. Dio	d tobacco i	use contribute to	the cause of death?
es that igned b	ρ					Yes 2	No 3 Pro	bably 4 🗸 Unknown
w requires that as been signed be should be deta	letec				24a Wa	as an topsy		utopsy findings available completion of cause of
The law cate has page 2 s	Completed		<u> </u>		pe 1 ✓ Ye	rformed? s 2 N	death?	es 2 No
ysician: The l his certificate b director, page	Be	25 Was case referred to medical examiner? Hospital:	o □ 50/0 to	26.Place of Death (75		
ling Phys After this funeral di	<u>د</u>	1 Yes 2 No 1 Inpatient 27 Manner of Death 28a Date of Injury	28b. Tim	e of Injury 28c. Injury at Work		oe how inju	ence 6 🗸 Othe	r: Scene
Attendin r death. ector: A by the fu	ation	1 Natural 5 Pending FOUND: Accident Investigation May 4, 2006	7 FOUND 0550 hi	1 1 103 2 107	No Subject st	truck an	id cut	
pital or Attending Physician: The law requires that the death certificate bours after death. eral Director: After this certificate has been signed by the attending physifiled in by the funeral director, page 2 should be detached for use as the bu	Certification:	3 Suicide 6 Could not be 28e. Place of Injur		, street, factory, office building, etc	or Town	n, State)		ural Route Number, City
Hospita 4 hours unera ely fille	S	29a. Certifier 1 Continue Physician To the best of my k				-	67, Mount A	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	edical	(Check only one) 2 Medical Examiner: On the basis of examinary and manner stated.						
F × F ŏ	Me	29b Signature and title of certifier		29c. License number			Date signed (Mo	nth, Day, Year)
		30. Name and address of person who completed deuse of dea	oth (Item 325)	O.C.M.E.		IVIAY	y 4, 2006	
3		Theodore King MD. Assistant Medical Ex	aminer 11	Penn Street, Baltimore,	MD 21201			
	_	31. Date filed (Month, Day, Year) 6 2006 32. registrar's	Signature	porte				

		1	For State Registrar		State of	f Marylan		artment of lartificate of			-	giene Reg. No.2	2006	15421
	*		Decedent's Name (First	, Middle, Las	t)					1	2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic	ai	Edwar				So	dosky			05	i 2_	2006	06:43M
	Examin		4a. Facility Name (If not in					4b. City, Town,		of Death			County of Death N/A	
	1000	<i>P</i> : 1	Loch Raven				forms to limbour on a	Baltime If Under 1 Year		r 24 Hrs.	8. Date of Birt		0.014	place (State or Foreign
	Funeral Director		5. Social Security Number 235-22-1830		x M 2□F	7. Age (In yrs. 83	Yrs.	Months Days		Min.	Jan. 17	y, Year) 7 192	3 West	intry)
	-74	- 1	Usual Residence of Dece	dent							an. I	, 1 / 2	3 1.000	
	yland	. [10a. State 10b.	County			y, Town or Lo							10d. Inside City Limits
	e Marita	cto	Maryland	N/A		Ва	1timor	e						XX Yes 2 No
	th with th		10e. Streel and Number 603 W. 36th	Street	:			10f. Zip Code	21211			10g. Citiz	en of What Cou USA	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to the Haulb and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other treumstic avent, it a Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Dece Armed Fo 1 DYes If Yes, Giv Year or D	2 □ No /e		Was Decedent of If Yes, specify Cul	an, Mexica	an, Puerto A	ofy Yes or No lican, etc.)		4. Race - Amer Black, White Specify: Wh	
5-0	72 ho natur	etec		ecedent's Ed	ucation de completed)		(Give	dent's Usual Occu	during mo	st of working	g	16b. Kin	id of Business/li	ndustry
121	han ne	Completed	Elementary/Secondary	(0-12)	College (1	I-4or 5+)		DO NOT use retire Tour Gui				USS	Torsk	
2	filed v Hygie thar t	ပ္ပ	17. Father's Name (First,	Middle, Last)			mead			ner's Name	(First, Middle,	, Maiden S	Sumame)	
Maryland	Mental Merked o	To Be	Steven Stan	ley So						y Por		0.	7 0 7	- 0 1
-	and 2 sh salth and n 27 is m er treum		19a. Informant's Name/R Etta Virgin	_ ` :	· .	Wife	603	W. 36th		et 1	Baltimo	ore,	Marylan	id 21211
Baltimore,	Pages 1 nent of He ant: If itan		20a. Method of Dispositio 1 Burial 2 Crei 4 Donatton 5 C	mation 3 🗌		State	cemetery, cre	osition (Name of matory or other plait of Fait		05/15	/2006		erton,	own, State Maryland
Balti	permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other tree		21. Signature of Funeral	Service Licen	Hens	13)	P 3	2. Name and Addi urgee-He 631 Fall	ess of Faci nss-S s Roa	eitz d. Ba	Funera 1timor	1 Hom e, Ma	ne, Inc. aryland	21211
			23a. Part1. Enter the dis- shock, or heart failu	ease, or comp	olications that cone cause on e	aused the deat	th. Do not en	er the mode of dy	ing, such a	s cardiac or	respiratory a	rrest,		Approximate Interval Between
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יוון	be executed icien and burial-transit	Xar	that initiated events resulting in death) Last		c. Due to	(or as a consec	quence of):							
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9	tificate ng phys as the	0												
P.O. Box	that the death certificate ed by the attending phys detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregin the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 ☐ Live t	tcome of pregnation 2 ☐ Feta nant at time of co own	al death 3[□Ectopic pregnan □ Other (specify)	су			2	3d. Date of deli Month	very Day Year
	res that the signed by be detaction	by Ph	Part II. Other significant	conditions c	ontnbuting to d	eath but not res	sulting in the u	ınderlying cause g	iven in Parl	t I.	23e. Did t	tobacco us	se contribute to	the cause of death?
rds	requires seen sign hould be	d be	decub	he	ulce	v -	bad	<u></u>			1 🗆	Yes 2	⊒No 3 □ Pro	obably 4 Unknown
Reco	The law requir sete has been si page 2 should I	Completed						-				psy ormed?	prior to c death?	topsy findings available ompletion of cause of
ta		0	25. Was case referred to	medical					26. Pla	ce of Death	(Check only	2 Ho one)	10.163	25140
Ž	ys d	To B	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA	ther: 4 1	Tursing Hom	ne 5 Resi	idence 6	Other (Spec	ufy)
o uo	Jing After fune		27. Manner of Death 1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending Investigation		of Injury th, Day Year)	28b. Time of Injury	W	ury at ork?] Yes 2[8d. Describe	how injury	y occurred	
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:		Could not be determined	28e. Place	e of Injury - At h ing, etc. (Speci	nome, farm, st	reet, factory, office	•	2	8f. Location (City or To			ral Route Number,
	Hospital 24 hours Funeral stely filled	Medical C			niner: On the b			th occurred at the evestigation, in my						
	To the within 2 To the complex	Me	29b. Signature and title of				<u> </u>		nse numbe				e signed (Month	
	->-0		D, A.	11.	nice	MD		1)	47	204		0	5/12/	2006
- 1	etl		30. Name and address of	f person who	completed cau	se of death (Ite	m 23a) (Type	Print) BLVd	8	a(h:	nois	M	D 21	218
	St	ate	31. Date filed (Month, Da	iy, rear)	29. F	Registrar's Sign	ature	- OCVA						
	Regist		MAY 1	6 2006	10 m	Registrar's Sign	dos	16 1						

			For State Registrar	State of Mary		artment of F			giene	16	15422
秀	1 But 1		Decedent's Name (First, Middle, Last	st)				2. Date of De	ath		3. Time of Death
	Physici		STELLA H. SI	HIVES				Month MAY 10	Day 0. 2006	Year	5:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give		0	4b. City, Town, o	r Location of Dea		4c. County	of Death	
			GLEN BURNUS	= HEALTH	1 & KEHA	B GU	EN 130	RNIE	A·	4	
	Funeral		5. Social Security Number 6. S		yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hr Hours Mir). (Month, Da	y, Year)	9. Birthpl Count	ace (State or Foreign
	Director		216-32-8/5/	□M 2XF 7	O Yrs.			JAN 4,	1936	Ohio	
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10	Od. Inside City Limits
	Aaryli 1 sho	ō	Marvland Anne Art	indol	Linthic	11m					1 ☐ Yes 2 ☑ No
	28a-	Director	Maryland Anne Art	ilidei	DITTOTIC	10f. Zip Code			10g. Citizen of W	/hat Coun	try?
	Sa or		556 Shipley Rd.			21090			United	Stat	es
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No		- America	
က္	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify Cubi	Specify:	eno Hican, etc.)		k, White, e	otc.
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show ideal Evantinar must be nydithed at	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify.		Specify.	Whi	te
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121	within ene. then	Id II	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	a)				
2			17. Father's Name (First, Middle, Last)		Home	maker	18 Mother's N	ame (First, Middle,	Own I		
anc	ag la b	Be	_					a Barzyko		-,	
7	d 2 should th and Mer 7 is marke traumatic	^L	John Przestrzels 19a. Informant's Name/Relationship (19b. Mail	ing Address (Street				State, Zio	Code)
Maryland	traum		Harry Leo Shives			Shipley R		hicum, M			
ē,	s 1 and f Health ltsm 27 other tr		20a. Method of Disposition	4	Ob. Place of Disp			Date	20c. Location -		wn, State
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donatign 5 ☐ Other (Specif	Removal from State	·=	en Mem. P		15.2006	Glen Bui	nie.	MD
alti	arta arta		21. Signatur Funeral Service Licer			2. Name and Addre	ss of Facility	Funeral			
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	/Medical Examiner		resulting in death)	Due to (or as a co							
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Вох	leath certificat attending phy I for use as th	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Dat	e of delive	ry
ă	death e atte d for	Cla	in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 2□ 4□Pregnant at tim		□Ectopic pregnanc □ Other <i>(specify)</i> _	У		Mor	nth	Day Year
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	8 5 0	by F	Part II. Other significant conditions of	_	ot resulting in the	underlying cause gr	ven in Part I.	23e. Did t	/		e cause of death?
ord	w require been si		USTEOPOR	20545				1	Tes 2 □ No	3 Prob	ably 4 □Unknown
of Vital Records,	e law r has be se 2 sh	Completed	MORBIT	OBEC	1TY			24a. Was	psy p	rior to cor	osy findings available inpletion of cause of
<u> </u>		Co						1 ☐ Yes		leath?	21 No
/ita	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1.0#	26. Place of D	eath (Check only	one)		
of	Phys this al dir	2	1 ☐ Yes 2 Ø No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	ent 3 DOA	4 Nursing	1	how injury occurr		')
LO	ding After fune	tion	Natural 5 ☐ Pending	(Month, Day Y	ear) Injury	Wo	rk?]Yes 2∐No	200. 2000.120			
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not b	e 28e. Place of Injury	- At home, farm, s	treet, factory, office			Street and Numb	er or Rura	l Route Number,
Σ	# # # E	Certification:	4 Homicide	building, etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the			nysician: To the best of n							
	the H iin 24 the Fi	ledical	one)	and manner stated				curred at the time,			
	To To	Σ	29b. Signature and title of certifier	1)911).1-	29c. Licens	se number		29d. Date signed		2
			Inclas	161	- 011) d	0651	7	TAY	4	000
	8		30. Name and address of person who		h (Item 23a) Type	NONGTO	AI)	e 131	171111	100	006 21226
	,	ate		SHEIZ 47 Registrar's		101/06/6	100 - 400	1-10	1010	nc	01000
1	Regist		31. Date filed (Month, Pay, Year) MAY 1 6 200	06	J. As	and I					

			1 - State Registrar	te of Maryland / Dep <i>Ce</i>	ertificate of E		ntal Hygien Reg. N	2 U U b	15423
	Physici		1. Decedent's Name (First, Middle, Last) OZRO RICHARD STE	IGELMAN			Date of Death Month	Øo€ Year	3. Time of Death 5:00 p M
)	/Medio Examin		4a. Facility Name (If not institution, give street at 16220 FALLS ROAD		4b. City, Town, or MOI	Location of Death	4	c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 221-18-0078	7. Age (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min. FEE	Date of Birth (Month, Day, Yea 3RUARY	9. Birti 19,1931	hplace (State or Foreign untry) PA
poelv	how In		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
the Ma	r 28a-f e notified	Director	MD BALTIMORE 10e. Street and Number	M	10f. Zip Code	01111	10g. C	Citizen of What Co	
U X I X I 3-0030	"naturel", or iteme 23a or 28a-1 ehow edical Examiner must be notified at	Funeral	1 Never Married 2 Married 1 X	Yes 2 □ No		2 1 1 1 1 Spanic Origin? (Specify, Mexican, Puerto Ric	y Yes or No- an, etc.)	USA 14. Race - Ame Black, White	ncan Indian.
5.13-00-c1:	n "naturel", o	Completed by	15. Decedent's Education (Specify only highest grade comp.	es, Give r or Dates: 16a. Dec Give Gi		tion uring most of working		Specify: Kind of Business/	•
E 9	E D A	o Be Com)+		18. Mother's Name (F		n Sumame)	IN
Mary	ulth and Menta 27 ie marked r traumatic ex	Ţ	19a. Informant's Name/Relationship (Type, Print EMMY LEE STEIGELM	19b. Mail	ling Address <i>(Street</i> a	nd Number or Rural R RD • MON P	oute Number, City	or Town, State, 2	Zip Code)
annimore,	Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, cre GREEN	ematory or other place	MAY 12		Location - City or BALTIM	Town, State
Dall	Departn Imports any njk		21. Signature of Equipment Arvice Licensee	140		s of Facility HENE YORK ROAI			& SONS CO. 21111
,	hysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not end on each line. Cronory Ortery	nter the mode of dying	, such as cardiac or re	spiratory arrest,		Approximate Interval Between Opset and Death
	/Medical xaminer	٦		ue to (or as a consequence of): ue to (or as a consequence of):	aid failur	2			idas
cate he executed	ysician and	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequence of):					
D X	nding Ise a	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
ecords, F.O. Do	been signed by	ρ	Part II. Other significant conditions contribution Diabetes type 2	-	underlying cause give	n in Part I.	/		the cause of death?
r g	ate h page	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
I Vital	or this certificate has	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3□ DOA Cthe	26. Place of Death (C		6 □Other (Spec	cify)
VISION OF VITA	# # E	Certification;	2 Accident investigation	Date of Injury (Month, Day Year) Place of Injury - At home, farm, s building, etc. (Specify)	M 1□Y	es 2 □No	Describe how in Location (Street a City or Town, Sta	and Number or Ru	ıral Route Number,
	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Cert	29a. Certifier 12 and ying Physician (Check only 2 Medical Examiner: On	To the basis of examination and/or id			dua to the cause(s) and manner as	
Tothe	within To the	Med	29b. Signature and title of certifier	^	29c. License	number S Z	29d. D	sate signed (Monti	h, Dey, Year)
10	+1		30. Name and address of person who complete Mank Comm	d cause of death (Item 23a) (Type	"TVALLY	M) 2103	0		
	Sta Registi		30. Name and address of person who complete MAK (QMM) W 31. Date filed (Month, Day, Year) MAY 1 6 2006	32. Registrar's Signature	posts				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

		•	For State Registrar	State of Mai		e <i>rtificate of l</i>			llene 2 () leg. No.	06	15424
	Dhysiair		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Mary Frances Sins			T		1	1, 2006		1:20 P M
	Examin		4a. Fecility Name (If not institution, give	street and number)			r Location of Death	n	4c. County		
			2501 Sinsko Lane 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthda)	Joppa // If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Harfo		lace (Stete or Foreign
	Funeral Director			□M 2 X 2F 8		Months Days	Hours Min.	8. Date of Birth (Month, Dey April 2	, Year) 9 - 1919		lace (Stete or Foreign stry) Virginia
	ס		Usual Residence of Decedent						312323		
	arylar show	_	10a. State 10b. County		10c. City, Town or I	_ocation				1	0d. Inside City Limits 1 ☐ Yes 2X No
	8e-f	Director	Maryland Harford 10e. Street and Number		Joppa	104 7:- 0-4-		·····	log. Citizen of V	4/2-24 Cours	
	a or	Ö				10f. Zip Code 21085				viiat Cour	ury r
	ns 23	Funeral	2501 Sinsko Lane	12. Was Decedent Ev	ver in U.S. 13	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-		e - Americ	
50	4 within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28e-f show The Macinal Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 Æ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 XNo	an, Mexican, Puert Specify:	o Rican, etc.)	Specify	ck, White, Wh:	
0500-CI	2 hou	ted	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occupa re kind of work done of	ation	rting	16b. Kind of Bu	usiness/Ind	dustry
7	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired	during most or wor	King			
7	77	Cou	8		Ho	memaker			Own H		
yland	0 = 5	Be	17. Father's Name (First, Middle, Last)	1				me (First, Middle,		16)	
<u> </u>	2 should be f and Mental I is marked of raumatic eve	ပ္	John Floyd Arnold		19h Ma	ling Address (Street a		Jane Ha		State Zin	Codel
M	th and the street traum		Janice Arnold/dauc	,, ,		Sinsko La					0000)
a)	f Healitem	1	20a. Method of Disposition	·		position (Name of ematory or other place			20c. Location -		wn, State
Ê	Page ent of nt: If i		1 ☑ Burjal 2 ☐ Cremation 3 ☐ 1 ☑ Johnstion 5 ☐ Other (Specify	Removal from State		<i>Memorial</i> G		15, 2005	Aberde	en. N	Marvland
saitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic enones.		21. Signatura of Frindral Service Licen			22. Name and Addres	ss of Facility M	cComas F	uneral	Home,	P.A.
			23. Parti. Enter the discourt comp	plications that caused t		L317 Coltes				21003	Approximate
			23/ Part. Enter the second my shock, or heart failure. List only Immediate Cause (Final	one cause on each line).				001,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. SCh	consequence of):	Heavi	Dise	ase			
	Examiner			L	oonooquonoo orj.						
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
ρΩ'	ificate be executed g physician and as the burial-transit	ai Ex	resulting in death) cast	Due to (or as a	consequence of):						
08/60	licate I physi s the t	edicai	•	d							
		√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		_			23d. Dat	e of delive	nry
XO RO	death cert e attendin d for use	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at ti		□Ectopic pregnancy □ Other (specify)	/ 		Мо		Day Year
Ö	the y th	hys	9 Unknown	9 Unknown							
Ś	as this gned be de	by F	Part II. Dther significant conditions of	ontributing to death but	not resulting in the	underlying cause give	en in Part I.				ne cause of death?
ecord	w require been si should I	ted	Congestive	Heavi	taile	are -		1 🗆 Y	es 2 DN 6	3∐ Prob	ably 4 □Unknown
ပ္	law law law las be	Completed	Renal 7	ailure	, ,			24a. Was a autops	sy r	prior to cor	psy findings available impletion of cause of
<u> </u>	40 FT		Chronic	Atrick	Ihal	lation		perfor		death?	202 No
VITA	certif rector	Be	25. Was case referred to medical examiner?	Hospital:	10011	ont all post Othi	05	ath (Check only or			
Ö	Phy ald	To It	1 Yes 2 No	28a. Date of Injury (Month, Day		BIIL JE DOA	4 🗆 Nursing n	lome 5 Reside			/)
0	th. : After s funer	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Yeer) Injury		k? Yes 2 ☐ No				
DIVISION	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, : (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rura	I Route Number,
	urs afte rel Dir rel Dir lled in										
	To the Hospitel or Al within 24 hours after of To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of a and manner state	examination and/or	ath occurred at the tin investigation, in my o	me, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and ma late and place, a	inner as st and due to	ated. the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	A		29c. License	e number	2	9d. Date signer	d (Month,	Dey, Year)
	- 510		· (Ylan	w MK	/	D	19TF2		Max	12	2006
ľ	y 1		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ-	e, Print)	Louis		4	XI	27001
1			Mannel M.	Lezati	MI		8 W	inst	vee 1	1×b	evapeen
	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar	's Signature	land .			1	RVY	JUN CK
	Registr	ar	MALLDZ	UUU E TO ME LO	1 65 6	Tree State of					

Mary Sinsko

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment or rtificate				iene,	16	15425
	Ty.		Decedent's Name (First, Middle, Last)						2. Date of Deat	th		3. Time of Death
	Physici /Medio		Joseph Julius Si	mmeth					May 13,	2006	Year	7:25 P ^M
	Examir		4a. Facility Name (If not institution, give s			4b. City, To	own, or	Location of Death		4c. County	of Death	
		18 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1416 Overlook Way	7		Bel A	Air			Harfo	ord	
	Funeral Director		5. Social Security Number 6. Sex 219–26–4776	7. Ag	e (In yrs. last birthday, Yrs.	If Under 1 Months [Year Days	Hours Min.	8. Date of Birth (Month, Day) Feb. 26	Year)	Cour	lace (State or Foreign try) Many
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	acation					1	0d. Inside City Limits
	eho	ō	Maryland Harford		Bel Air	ocation					'	1 ☐ Yes 21 No
	28a-	Director	10e. Street and Number		302 142	10f. Zip C	ode		1	0g. Citizen of W	hat Cour	ntry?
	With Se or	ā					014			USA	nut oour	
	me 2;	Funeral	1416 Overlook Way	12. Was Decedent I	Ever in U.S. 13.	Was Deceder	nt of His	spanic Origin? (Sp	ecify Yes or No-		- Americ	an Indian,
36	hours after death with the Maryland turel', or Iteme 23e or 28e-f ehow il Examinat must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2√ ↑ If Yes, Give Year or Dates:	40	If Yes, specify		Specify:	Rican, etc.)	Specify:	t, White,	etc. ite
Ö	72 hours "naturel", of cell Exe		15. Decedent's Edu	cation	16a. Dece	dent's Usual (Occupa	tion		16b. Kind of Bus		
215	within 72 ene. than "nat he Medic	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life.	kind of work DO NOT use	done du retired)	uring most of work	ing			,
21	filed within Hygiene. other then	Completed	Elementary/Osseridary (3 12)	2	1	ness O	wne:	r		Butch Sl	nop a	& Deli
P		Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, I	Maiden Sumame	9)	
yla		၉	Josef (nmn) Simme	th				Albine	(nmn) Hi	ltl		
Maryland 21215-0036	0 6 00 7		19a. Informant's Name/Relationship (Type			-		nd Number or Rur		-		
e,	1 and 2 Health tem 27		Elizabeth Simmeth	/ wire	20b. Place of Disp		400	Way, Be				
Baltimore,	<u>~</u>		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre	matory or othe	er place)		20c. Location - (
Ë	it. Pa		4 Donation 5 Other (Specify) 21. Signature of Fune/al Service (Specify)		Bel Air M					Bel Air	, Ma:	ryland
Ba	permit. Page Department of Important: If eny Injury or		Mula UE	ug I		$317 \mathrm{Co}$	kesl	s of Facility neral Hor bury Road	d, Abing	don, Ma:	rylaı	nd 21009
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only of	edions that caused e cause on each lir	the death. Do not en	ter the mode o	of dying	, such as cardiac	or respiratory arri	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Meta	static .	nonsm	ull	cell le	neg Cov	cer	3	Onset and Death months
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				0			
	xa,,,,,,,	<u>.</u>	Sequentially list conditions,	. Due to /or on	a consequence of):							
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence on.							
•	xecur and al-trai	хаг	that initiated events resulting in death) Last	Due to (or as	a consequence of);							
8760,	icate be executed physicien and s the burial-transit	dicai E										
687	ificate p phy.	edic										
.O. Box	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic preg ⊒ Other (s <i>pec</i>				23d. Date Mon		ny Day Year
Q	that the poly of t	by Ph	Part II. Other significant conditions cor	tributing to death b	ut not resulting in the t	inderlying cau	se givei	n in Part I.	23e. Did tot	pacco use contri	bute to th	e cause of death?
rds	quires an sign uld be								1 X Y6	es 2 🗆 No	3 🗌 Prob	ably 4 Unknown
Vital Records,	The law requires that cate has been signed b page 2 should be deta	Completed							24a. Was a autops perform	y pi n,ed? de	nor to coreath?	psy findings available ripletion of cause of
ta		ပိ	25. Was case referred to medical					26. Place of Deat	-	-	☐ Yes	2 ∐ No
	Physician: this certific ral director,	o.	examiner?	ospital:	nt 2 ☐ ER/Outpatie	nt 3 DOA	Other		ome 5X Reside		r (Specifi	/)
101		ı: ı	27. Manner of Death	28a. Date of Inju	ry 28b. Time o		. Injury Work		28d. Describe ho			,
jo	Attending r death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(111011111)	, , , 52.7	М		es 2 No				
Division of	after de Directe	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, ele	ury - At home, farm, st c. (Specify)	reet, factory, o	office		28f. Location (St City or Town		r or Rura	l Route Number,
Ω	Hospital or 44 hours afte Funeral Dire felled in the		6									
	To the Hoepital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Medical Examin	ner: On the basis of and manner sta	of my knowledge, deal examination and/or in ited.	h occurred at vestigation, in	the time my opi	e, date and place, inion, death occur	and due to the ca red at the time, d	ause(s) and man ate and place, a	ner as st	ated. the cause(s)
	To the P within 24 To the P complete	Σ	29b. Signature and title of certifier					number	.5	9d. Date signed		
•	6		· Jan				, 2 ,	4841		5/15	100	
6			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type	Print)		-				
2	A CONTRACTOR		31. Date filed (Month, Day, Year)	22/Penistr	ar's Signature			N - N - N - N - N - N - N - N - N - N -	- A-A	25.4		
	Sta Registr		MAY 1 6 20	NS A SOURCE	ars Signature	actes.						
*	AN 20		Hilli T O CO	J. A. MERK	The Sal Miles							

	For State Registrar	State of Marylan		nent of H <i>cate of L</i>			giene 2 (Reg. No.	006	1542
	1. Decedent's Name (First, Middle, Last)			• • • • • • • • • • • • • • • • • • • •		2. Date of Dea Month	nth Day	Year	3. Time of Death
Physician /Medical	SEYMOU	R	STEI	NBERG		May	8	2006	0050 AM
aminer	4a. Facility Name (If not institution, give s			City, Town, or	Location of Death		4c. County	of Death	_ %
	SINAY HOSPITAL C	OF BALTIMORE		ALTIMO					N/A
neral ector	210 12 0211 //	M 2□ F 7. Age (In yrs. 84		Under 1 Year Inths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Manth, Ca U3/U	5/ T 922	9. Birthpli Count	ace (State or Foreign
*	Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Locatio	n				10	Od. Inside City Limits
Important: If item 27 is marked other then hatural, or lems 23s or 25e-1 enow any Injury or other traumatic event, the Madical Exacutant must be inclified at page. To Be Completed by Funeral Director	MD N/A		BALTIM						1 ☑ Yes 2 ☐ No
funeral Director	10e. Street and Number			Of. Zip Code			10g. Citizen of	What Count	
10	3635 GLENGYLE AV	ENUE #5C			21215				USA
lera		2. Was Decedent Ever in U.	.S. 13. Was	Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Rad	e - America	
Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 (X)Yes 2 □ No If Yes, Give				Hican, etc.)		ck, White, e	etc.
l by	3 X Widowed 4 □ Divorced	Year or Dates:		res 2X No	Specify:		Specif	y:	WHITE
Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's	of work done a	furing most of work	ing	16b. Kind of B	usiness/Ind	lustry
μ	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life. DO N	IOT use retired,)		DACET	DACK	
ပိ	12		VENDOR		40 14-15-1-1-1	- /m' A A A'-1-11-	RACET		
Be	17. Father's Name (First, Middle, Last)		CTEIND	EDC	18. Mother's Nam	e (First, Middle,	Maiden Sumar	ne)	DUKATZ
ဥ	HENRY	- Dian	STEINB			-10- 4- 111	- 0's T	C4-4- 7:-	
4	19a. Informant's Name/Relationship (Typ. DORA GOLFETTO /	DAUGHTER			and Number or Run STREET				
	20a. Method of Disposition		Place of Disposition			TION -	20c. Location		
	1 X Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	emetery, cremator	y or other place	θ)				
	4 Donation 5 Other (Specify)				CHAIM)		HALET		
Suc	21. Signature of Funeral Service License	7		me and Addres		OL LEVII			
_	O'So Posts Follow the discourse or sometime	ations that sourced the deat						ILLE,	MD 21208 Approximate
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	n. Do not enter th	a mode of dying	g, such as cardiac	or respiratory ar	rest,		Interval Between Onset and Death
n al	Immediate Cause (Final disease or condition resulting in death)		40 con 010	1 Injur	rution				1 day
r		Due to (or as a conseq	uence of):	O				100	
-	Securitially list punditions b	Due to (or as a conseq	uanca of):						
Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,						
X	resulting in death) Last	Due to (or as a conseq	uence of):						
cai	L _d								
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Da	te of deliver	ry
icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		opic pregnancy er (specify)			Mo	onth I	Day Year
hys	9 Unknown	9□ Unknown							
	Part II. Other significant conditions con	^	ulting in the underl	ying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?
ed	Isunemic condign	mopathy				1 🗆 Y	'es 2□No	3 ☐ Proba	ably 4 🗹 Unknown
Completed by) . 0				24a. Was	an 24b.	Were autop	sy findings available
E						perfor	med?	death?	
0	25. Was case referre medical				26. Pface of Deat				
ToB	examiner? 1 ☐ Yes 2 ☐ No	ospitaf: 1 Inpatient 2	ER/Outpatient 3	□ DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Resid	lence 6 Oth	ner (Specify))
	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	ow injury occur	red	
atic	2 ☐ Accident investigation				Yes 2 □ No				
Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, t	actory, office		28f. Location (S City or Tox	itreet and Numl m, State)	er or Rural	Route Number,
Se		1							
	(Check only 2 ☐ Medical Examin	ician: To the best of my kno er: On the basis of examina	wiedge, death occurring and/or investig	urred at the tim	ne, date and place, pinion, death occur	and due to the or	cause(s) and m	anner as sta	ated. the cause(s)
Ca	one)	and manner stated.		29c. License	number		29d. Date signe	d (Month 5	Pau Vaarl
Medical	29h Signature and title of certifier					1	Lou. Date signe	G (MOHII), L	aj, real)
Medical	29b. Signature and title of certifier			00	200		. 1	~	- /
-	b Uhenner Six las	em		RES	9-000		May !	3, 20	006
completely in	29b. Signature and title of certifier 30. Name and address of person who could be a supplied to the supplied	mpleted cause of death (Item			9-000 N 011-1.	0.006	May !	3, 20	006
8	b Uhenner Six las	mpleted cause of death (Item	JAI HOS.	1	9-000 OF BALTI	more	May !	3, 20	006

		State of Maryland / [State of Maryland / [Department of Health and Note of Certificate of Death	Mental Hygi	•	151.27
Physici /Medi		1. Decedent's Name (First, Middle, Last) Stanley Arnold Truman, Sr.		2. Date of Death	2006 Year	3. Time of Death 5:30 а м
Examir		4a. Facility Name (If not institution, give street and number) Gilchrist	4b. City, Town, or Location of Death Towson		4c. County of Deat Baltimon	
Funeral Director		297-20-0010	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, 1) June 28,	1923 Oh 10	hplace (State or Foreign puntry)
faryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Maryland Baltimore Owing:	n or Location S Mills			10d. Inside City Limits 1 ☐ Yes 2X No
with the Na or 28a-	i Direct	10e. Street and Number 10315 Lyons Mill Road	10f. Zip Code 21117	10	g. Citizen of What Co United S	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exact in artificial at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 New II 14. Was Decedent Ever in U.S. Armed Forces? 15. Yes 2 New II 17. Yes 7 Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
vithin 72 ho ne. han "natur a Medical i	Completed	Elementary/Secondary (0-12) College (1-40r 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) aims Adjuster		Sb. Kind of Business/	
id be filed v fental Hygie rked other t	To Be Co	12th – C1 17. Father's Name (First, Middle, Last) Delbert L. Truman		e (First, Middle, Ma Canode		
ind 2 shoualth and Na		19a. Informant's Name/Relationship (Type, Print) Mrs. Alberta Truman (Wife) 19b	o. Mailing Address (Street and Number or Run 0315 Lyons Mill Road,	Owings Number,	City or Town, State, 2 Mills, MD	Zip Code) 21117
Pages 1 and of Height of H		cemeter	ry, crematory or other place) Orematory May 12, 2	.006 Ca	oc. Location - City or	, MD
permit. Departm Importa any inju		21. Signature of Funeral Service Licensee Joseph Kellson Moo 333	22. Name and Address of Facility Lor 8728 Liberty Rd., R	ing Byers andallst	s Funeral own,MD 211	Directors, I 33-4784
Physician /Medical Examiner		23a. Part . Enter the disease or complications that caused the death. Do sheck, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac mphoma	or respiratory arres	it,	Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
quires that n signed build be deta		Part II. Other significant conditions contributing to death but not resulting in Chronic Obstrative Cur	n the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
The law recate has bee page 2 shoo	Completed by	covering Artery disease	· ·	24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
hysician: his certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Cther: 4 Nursing Ho	th <i>(Check only one)</i> ome 5 \(\subseteq\) Residen	ce 6 Dother (Spe	city) HOSPICE
tending P eath. for: Alter t	Certification:	1 ∰Natural 5 □ Pending (Month, Day Year) I	Time of 28c. Injury al linjury M 1 Yes 2 No	28d. Describe how		
oital or At urs after d oral Direct		4 Homicide determined building, etc. (Specify)		City or Town,		
the Hosp hin 24 hou the Fune npletely fi	Medical	29a. Certifier (Check only one) 1	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	red at the time, dat	ise(s) and manner as e and place, and due d. Date signed (Monta	to the cause(s)
, <u>,</u>		Mil Ashing My, in	o Dasas		MAY	
1041		30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) 32. Registrar's Signature,	(Type, Print) 6601 N. Citar Towson, M.	LES STR 1D ZIZO		
Sta Registi		31. Date filed (Month, Day, Year) 32. Refistrar's Signature	South			

				State of Maryland / Departmen 1 - State Amend Item#20b per FH G855 5/17/06 C Registrar	e of Death	R	eg. No.	<i>J</i> (<i>J</i>	15428
		Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Deat Month		Year	3. Time of Death
		/Media	cal	Francisca Ngozi Uwansc		May		006	8:47 P M
		Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Gilchrist Hospice	Town, or Location of De Towson	eath	4c. County Ba	or Death 1 t i mo	ore
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		rs. 8. Date of Birth in. (Month, Day,	Vear)	9. Birthr	place (State or Foreign
		Director		214-45-9694 1 43 Yrs.	Days 110013 W	July 8,		Nig	eria
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	10d. Inside City Limits
		Mary a-f sh	tor	Maryland Baltimore Gwynn Oak					1 ☐ Yes 2 🌠 No
		th the	Director	10e. Street and Number 10f. Zip		1	0g. Citizen of V	Vhat Cour	ntry?
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	21215-0036	orsaf	by	3 ☐ Widowed 4 ☐ Divorced	No Specify:		Specify	В1	.ack
	5-0	72 ho	eted	15. Decedent's Education 16a. Decedent's Usus (Specify only highest grade completed) (Give kind of wo	al Occupation ork done during most of v se retired)	vorking	16b. Kind of Bu	siness/In	dustry
ξ	121	within ane. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Self Emp			Artis	t.	
<u>a</u>	9	filed Hygie		17. Father's Name (First, Middle, Last)		lame (First, Middle, M			
1	lan	id be fental rked c	To Be	Francis U. Ononye	Vin	ginia Odi	ari		
B	Maryland	shou and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or	Rural Route Number	, City or Town,	State, Zip	Code)
		and sealth m 27			ardson Road			_	
و 0	Baltimore,	iges 1 nt of H if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	other place)		20c. Location -		own, State [aryland
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_	Ba	Depar Impor any ir		M01283 Funera	nd Address of Facility 11 Home of (21 Mondson A	Catonsvill	e, Inc.	o M	D 21228
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N 17 2 SC	Вох	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pr			23d. Dat Mo	e of delive nth	ery Day Year
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3		s that the ned by the s detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying c	ause given in Part I.	23e. Did tob	acco use conti	ibute to th	he cause of death?
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	000	2 2	Completed			24a. Was ar		Vere auto	opsy findings available mpletion of cause of
	Ä	The law ate has b page 2 s	Com			perform	ned? d	eath?	2×No
	/ita	Physicien: The lav this certificate has ral director, page 2	Be (25. Was case referred to medical examiner?	1 -	eath (Check only on	θ)		16
	of	Physi this c	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC 27. Manner of Death 28a. Date of Injury 28b. Time of 2		Home 5 Reside		er (Specif	y) HOSPICE
	O	ding Physin. After this funeral di	tlon	1 Statural 5 Pending (Month, Day Year) 2 Accident investigation M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	20d. Describe no	w injury occurr	Bu	
	Division of Vital Records,	Atten r deat ector: by the	Certification:	3 Suicide 6 Could not be	7-17	28f. Location (Str	reet and Numbe	er or Rura	al Route Number,
	Ö	s afte ei Dir	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town	i, State)		
		To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier (Check only (Ch	at the time, date and pla	ice, and due to the ca	ause(s) and ma	nner as s	tated. the cause(s)
		thin 2, the f the f mplet	Med	one) and manner stated.	c. License number		9d. Date signed		
	1	T wit		250. Signification of Continent	D 5830		May		2-00 G
	•	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6601 N.CA	_	/	-	
		5		AATON J. CHARLES, MD	TOWSON ,				
		Sta		31. Date filed (Month, Day, Year) 32. Begistrar's Signature	,				
		Registi	ar	MAY I 6 2006 Reser & South					

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			1 State	State of Ma	aryland / l				ı Men		_ /	16	15629
			Registrar			Certifica	ate of L	veatn			eg. No.		10122
Н	Physici	an	Decedent's Name (First, Middle, Las		- > 1 > 1 ^	0				Date of Dea Month		Year,	3. Time of Death
	/Medic		LOULA		ENNA					MAY	14 20		0/:33 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	77177			Location of De	-		4c. County of	f Death	
			HARBOR HOSI	1146	ENTE	1	1)	IMOR			1		
н	Funeral		5. Social Security Number 6. Se	X 7. Agi	e (In yrs. last bii	Yrs. Month	der 1 Year ns Days	Hours M	lin.	Date of Birth Month, Day	Year)	9. Birthp	place (State or Foreign
	Director		216-28-0707 Usual Residence of Decedent	A	78	110.			26	ept. 1	, 1927	Gre	ece
	land		10a. State 10b. County		10c. City, Tow	n or Location						1	0d. Inside City Limits
	Many 4 sh	ō	Maryland Baltimo	ore	Cato	nsville	9						1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23s or 28s-f show rmust be notified at	Director	10e. Street and Number			10f.	Zip Code			1	0g. Citizen of W	hat Cour	ntry?
	23a or	۵	920 Rambling Dr:	ive			21228				US		
	Jeath v	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.			panic Origin?	(Specify	Yes or No-			an Indian,
10		Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 N	No			panic Origin? , Mexican, Pu	ierto Rica	n, etc.)	Black	, White,	
93		by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2 X No	Specity:			Specify:	Wh	ite
9	n 72 hours n "natural", Bolical Ext	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a	Decedent's U	sual Occupat	ion	working		16b. Kind of Bus	iness/In	dustry
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2	filed with Hygiene other the	9	6th			Home	maker				Own	ноте	
nd		Be (17. Father's Name (First, Middle, Last)				1				Maiden Sumame)	
yla		ဥ	John Hondroulis					Aligo	ета	Kondos	gorges		
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (7 Konstantinos L. V		a h						City or Town, S		
	カモトラ										lle, Mar		
Baltimore,	ges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place o cemete	f Disposition (f ry, crematory o	Vame of or other place,) į	Date		20c. Location - (lity or To	own, State
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alt	permit. Pa Depertmer Important any injury		21. Signature of Funeral Service Licen:	500 500		22. Name	and Address	of Facility S	terl	ing A	shton So	hwal) Witzke
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-	Physician		Immediate Cause (Final disease or condition	CFRF	BROW	ASCU	LAR	ACC	10	ENT		T	Onset and Death
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	Examiner		Sequentially list conditions	RENAL	TRAN	SITIC	MAL	CELL	CAR	CCIN	oma	1	WO MONTHS
	ס ≠	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
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760,	be executed icien and burial-transit	<u> </u>	resulting in death) Last	Due to (or as	a consequence	of):							
876	0 0	lcai	•	d								_	
89)	certifical	Completed by Physician/Med	IF FEMALE:										
Box	ath ce ttand or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetel death	3 □Ectopic	pregnancy				23d. Date Mon		ery Day Year
_	e de	SC	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death	5 Other	(specify)				IVIOIT	"	Day 16ai
P.O.	w requires thet the death been signed by the atta should be detached for	F.				- 4 4 - 4 - 2 -				00- Dida-			
	res th	à	Part II. Other significant conditions co	entributing to death bi	at not resulting i	n the underlyin	g cause given	ın Part I.					ne cause of death?
Records,	een s	ted							-	1 🗆 Ye	s 2 No :) FI Prob	ably 4 Unknown
ec	a so	de la							_	24a. Was a autops	n 24b. W	ere autorior to cor	psy findings available apletion of cause of
	ate pa	S								penfora 1 ☐ Yes	ned? _ de	eath?	2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of D	Death (Ch	eck only on	ө)		
7	Physi this c	္	1 195 2 2 10	Hospital: 1 Minpatie			,	4 U Nursing			ence 6 Other		1)
Division of	ing P	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	y Yeer) 28b.	Time of njury	28c. Injury a Work?	,	28d.	Describe ho	w injury occurre	d	
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			М		es 2 □No					
Z	or At after d Direct in by	E	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, fa c. <i>(Specify)</i>	irm, street, fact	ory, office		28f.	Location (St City or Town	reet and Numbe. n, State)	r or Aura	l Route Number,
	To the Hospitel or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	ပိ											
	Hospitel	Medical	(Check only 2 Medical Exam	vsician: To the best of iner: On the basis of	examination an	e, death occurr id/or investigati	ed at the time ion, in my opii	e, date and pla nion, death oc	ace, and a	due to the c t the time, d	ause(s) and man ate and place, ar	ner as st nd due to	ated. the cause(s)
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	10		30. Name and address of person who e	1 2			OCT	クスアマ	DA	T/00	ONT NA	An V	1 AND
	10		31. Date filed (Month, Day, Year)	32 maistra	de Cianatura			(56)	DAI	- 11/11	ORE.M	4KI	-NND
	Sta Registr			oc Ja. Pyistra	ars signature	Societ							
	3,31		MAY 1 6 20	Ub JUNE	N ST	1							

State Registrar Amend item#4a-c,10b,perMD,FH,G856,6723/101624712 of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 13, 2006 Year **Physician** Walton Mable /Medical 4b. City, Town, or Location of Death Bethesda Clinton 4a. Facility Name (If not institution, give street and number)
Southern Hospital
Southern Mary Land Hospita Montgonery Examiner Hospital 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5,1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 88 1 □ M 2 🖔 F Virgínia Director Usual Residence of Decedent 10c. City, Town or Location Prince George's 10d. Inside City Limits 10b. County 10a. State or 28e-f show r than "natural", or iteme 23a or 28e-f show the Medical Examinar must be notified at - Forestville Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20747 5022 Silver Hill Court Apt. 102 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ATTICAN 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: Š 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Retired 8th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any njury or other treumatic event 2008. Be Pannel1 Ambrosia Eugene Younger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5022 Silver hill Court Apt. 102 Forestville MD20747 Grace M. Walton (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place) Harmony Memorial Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 19, Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Road Clinton, MD20735 mo025 sours X. Arac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per fb 8856 6-9-06 yr. State of Maryland Department of Health and Mental Hygiene

3. Time of Death

5:20AMM

1 ☐ Yes 2 ☐ No

Approximate Interval Betwee Onset and pe

23d. Date of delivery

1 ☐ Yes

29d. Date signed (Month, Day, Year)

Month

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

page 2 should be detached has been this certificate death. s after death filled in by

Nathon, Mable Y. 5/13/06

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 24a. Was an autopsy ormed? 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

0 State

Registrar

31. Date filed (Month, Day, Year) MAY 1 6 2006

29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a To the Funerel [

06-03221

Please Type or Print in Black Indelible Ink

Willie Williams State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar dent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 13, 2006 Medical Examiner 0005 hrs 4b. City, Town, or Location of Death 4c. County of Death stitution, give sti Anne Arundel Maryland House of Corrections-Jessup Jessup 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Davs Hours Min Director Country) 2 Yrs Usual Residence of Deceder 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Xes 2 s 23a or 28a-f show e notified at once. 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director Street and Number 10g. Citizen of What Country Funeral Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, must be White, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Yes 2 No specify: Divorced If Yes, Give Year Widowed 1 Yes 4 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 1B.Mother's Name (First, Middle, Maiden Cremation 3 Removal from State Donation 5 Other Specify ature of Funeral Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter the Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Asphyxia and Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? ✓ Yes 2 No this certificate 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other₄ examiner? DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes ပ 28a. Date of Injury (Month, Day, Year) FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject assaulted Natural FOUND: Yes 2 🗸 No Pending To the Funeral Director: May 12, 2006 2235 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 2Bf. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State)
Maryland House of Corrections- Jessup, Jessup, determined (Specify) Jail/Penal 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E May 13, 2006 Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar

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ORIGINAL

P-00.30 72 hours after death with the Maryland fraction after death with the Maryland fraction from 23a or 28a-1 ehow bidget Examiner must be rediffed at the following fraction for the following fraction for the following fraction for the following fraction for the following fraction fracti	5. Social Security Number 6. Sex 213-32-5329 1	M 2005 7. Age (In yrs. It	Ast birthday) Yrs. Town or Location BALTIMOR 10f. 13. Was Dir.	a I HW nder 1 Year ths Days RE Zip Code	Location of Death LOCE LI- If Under 24 Hrs. Hours Min.	2. Date of Day Month May 8. Date of Bird (Month, Day APR 20	Day 12 4c. Count N th y, Year)	WEST	VIRGINIA			
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5-UU-36 72 hours after death with the Maryland natural; or iteme 23a or 28a-1 ehow digital Examinational be notified at etch by Funeral Director	MARYLAND N/A 10e. Street and Number 1314 RAMBLEWOO 11. Marital Status 1 □ Never Married 2 □ Married	DD RD 2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ XNo	BALTIMOE 10f. 6. 13. Was De	Zip Code				10				
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n n natura realcal		Year or Dates:		ecedent of Hi specify Cuba s 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - America ack, White, e	etc.			
E the with	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)		f work done d T use retired,	uring most of work		16b. Kind of E		,			
DEBILIMOTE, MARYIANG Z1Z1Permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event. It a Magnet. To Be Compl	12th grade 17. Father's Name (First, Middle, Last) JAMES OTEY		TEACHE	R(PARA			First, Middle, Maiden Sumame)					
, Mary and 2 sho saith and 1 n 27 io ma nor traums	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Martia Whelchel-JOHNSON/DAUGHTER 1314 Ramblewood Rd., Baltimore, Md.											
Maltimore, semit. Pages 1 at Department of Hea mportant: If Item my injury or othe page.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ace of Disposition (metery, crematory YLAND NA	or other place	9)	Date 20-06	20c. Location					
Departiment of the control of the co	21. Signatur Pupin Solving Line	eur	WILL	e and Addres IAM C I W NOR!	s of Facility BROWN CON TH AVENUE	MUNITY	FUNERAI	L HOME	P.A.			
Physician /Medical Examiner	23a. Pairt Ener the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	ence of):		, such as caldiac	or respiratory an	1001,		Approximate Interval Between Onset and Death I—Q day			
death certification of for use as iclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	Bc. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 □Ectopi	ic pregnancy (specify)				ate of deliver	ry Day Year			
	Part II. Other significant conditions cont	tributing to death but not resu	lting in the underlyin	ng cause give	n in Part I.		obacco use con	atribute to the	e cause of death?			
The law requires the law requires the law requires the law requires the law required to the law required to the law required to the law required to the law required to the law requirements the law r	VIABLIES							Were autop prior to com death? 1 \sum Yes	sy findings available pletion of cause of 2 No.			
on of VI	27. Manner of Death 28a. Date of Injury 28b. Time of Section of Injury 28c. Injury at Work? 28d. Describe how injury occurred								1			
To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After teampletely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 5 Homicide 1 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)						Street and Num. vn, State)	ber or Rural	Route Number,			
o the Hospitchin 24 hours thin 24 hours in the Euner Impletely fill.	29a. Certifier 1 Cartifying Physic (Check only one) 1 Cartifying Physic 2	ician: To the best of my know ar: On the basis of examinati and manner stated.	/ledge, death occur on and/or investiga	red at the tim tion, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as sta , and due to	ited. the cause(s)			
	29b. Signature and title of certifier 30. Name and address of person who con	mpleted cause of death (Item Sinai He	23a) (Type, Print)	29c. License			29d. Date signe May 16					

06-03130 Calvin Wyatt

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Certificate of	Death		., Re	eg. No. 20	16 1543
Physician/ Medical Examiner		dle,Last) Calvin	Wyatt			2. Date of Deat Month May 9, 200	Day Year	3. Time of Death 1146 hrs
	4a. Facility Name (if not institut	- · ·	4	b. City, Town, or L Baltimore	Location of Deat		4c. County of De	
Funeral	5 Social Security Number		yrs. last birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of Birt	N/A	Birthplace (State or
Director	218-14-0454	1XM 2F 82	Yrs.	Months Days	Hours Mir	April		reign Country) Maryland
any	Usual Residence of Decedent 10a. State 10b. Count	y [10c.	City, Town or Location	on				10d. Inside City Limits
*	Maryland	Baltimore	•		Dunda	1k		1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Bygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 8007 Gray Ha	wen Poad		10f. Zip Code	21222	10	Og Citizen of What C	ountry?
vith the s 23a o e notifi	11. Marital Status	12. Was Decedent Ever	in U.S. 13. Was	Decedent of Hisp		pecify Yes or No-	United S	tates nerican Indian, Black,
or items 23. must be no		Married Armed Forces?	If Ye	s, specify Cuban,			White, etc	
rs after ural", miner	15 5 1 2 51 11 10	ivorced If Yes, Give Year 1943 or Dates: pecify only highest grade complete		Yes 2 X No		work done	Specify. 16b. Kind of Busine	White
5-0036 ed within 72 hour tygiene. other than "natu inte Medical Exan Completed	Elementary/Secondary (0-12		during mo	st of working life.	DO NOT use ret	ired)	TOD, KING OF BUSINE	55/IIIdusti y
within within giene. Medig	10 Years 17 Father's Name (First, Midd)	o Lost\	V	Velder	O Mather's Nam	o (First Middle A	Steel Maiden Surname)	Industry
215- be filed ntal Hyg rked oth ent, the	William T.	•		,		e Barret	,	
D 21 should bend Mer is mar atic ev	19a Informant's Name/Relation	nship (Type, Print)	178				ber, City or Town, St	ate, Zip Code)
and 2 s and 2 s lealth a tem 27 traum	Charlene RO 20a. Method of Disposition	gers (Daughter)	20b. Place of Disposit			dalk, Ma Date	ryland 2: 20c Location - City	or Town, State
more	1 X Burial 2 Cremati 4 Donation 5 Other	on 3 Removal from State	crematory or othe Parkwood (' '	5/	13/2006	Baltimo	re, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Bygene. Important: If item 37 is marked other than injury or other traumatic event, the Medica To Be Comple	21. Signature of Funeral Service		22. Na	ame and Address	of Facility		Dundalk,	
Physician	23a Part I. Enter the disease,	or complications that caused the dise on each line.	/ i 79	22 Wise	Ave.	Dundalk.	Maryland	21222 Approximate Interval
/Medical	failure. List only one caus Immediate Cause (Final diseas	contrio onounce		o vascular	injury d	uring abdo	minal	Between Onset and Death
xammer	or condition resulting in death)	bue to (or as a conseque)	nce of):					
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	b	nce of);					
red Insit Examine	(Disease or injury that initiated events resulting in death) Las	c	nce of):					-
ffcate be executed g physician and sthe burial - transit n/Medical Ex.	X UNPENDED	dX AMENDED item#	423a 27 28a-1	F porMF a8	55 5/2///0	5 TTP	<u> </u>	
760, ficate be execu g physician and the burial - tra	IF FEMALE:	23c. If yes, outcome of	23a,27,28a- 26,perME,g8 pregnancy	56,6/29/66	TI 24/0		23d. Date of deliv	rerv
687 certific nding p ise as th	23b. Was decedent pregnant in past 12 months?	the 1 Live birth 4 Pregnant at time	2 Feta		Ectopic pregna	ancy	Month	Day Year
). Box 68 the death certif by the attending ched for use as	1 Yes 2 No 9 U	nknown 9 Unknown	3 Oth	er (Specify)				
P. C		litions contributing to death but	not resulting in the un	nderlying cause giv	ven in Part I.			to the cause of death?
Records, The law requirer ficate has been sig. page 2 should be Completed		.		.		24a Was a	n 24b. Were	autopsy findings available
ecol he law ate has age 2 sh						autops perform 1 ✓ Yes 2	med? death	
tal R cian: 1 certific ector, p	25. Was case referred to medic examiner?				of Death (Check	only one)		
of Vi	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of In		Other Nursin		Residence 6 Ot	her:
ion c tending eath. or: Af the fun		nding (Month, Day, Year) estigation May 9, 2006	unk	1 Ye	es 2XX No	Therapeut	ic misadvent	cure
Division o spital or Attending tours after death. Increa Director: Aft filled in by the fune Certification:	3 Suicide 6 Co	uld not be 28e. Place of Injury -	-	, factory, office bu	uilding, etc.	28f. Location (S	treet and Number or	Rural Route Number, City Administration
Hospita 4 hours 7 uneral ely fille	29a. Certifier	ermined (Specify) Hospi Physician: To the best of my known		ed at the time date	e and place and			
To the Hi within 24 To the Fi completed		aminer:On the basis of examination						
F P F O E	29b. Signature and title of certi	fier A 10	/	29c. License O.C.N			29d. Date signed (I	Month, Day, Year)
- Na	30 Name and address of person	on who completed cause of death	(Item 23a)	0.0.1	u.∟.		May 10, 2006	
10	Zabiullah Ali, M.D.	Assistant Medical Exami		Street, Baltir	more, MD 21	201		
State Registrar	107 / 1 V 7	6 2006 32. Registrar's Sig	gnature Aco	selle d				
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		51	Decedent's Name (Fire	rst, Middle, Las	t)						2. Date of D	eath		3. Time o	f Death
J.	Physici		Jeanette		F.		Wie	czyn	ski		May 1	2, 2	2006 Year	4:15	АМ
7	/Medic Examir	13	4a. Facility Name (If not	institution, give	street and numb	er)		4b. City	, Town, or	Location of Deal		-	c. County of Death		
			Riverview D	Nursina	Home			Es	sex				Baltimon	ce :	
<u>.</u>	Funeral		5. Social Security Number	er 6. Se	9X 7.	Age (In yrs. la		If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min		irth	9. Birth	Approximate Interval Belwery Day Year Country?	or Foreign
	Director		217–16–544	/	□ M 2 🟋 F	82	Yrs.	I WOTHERS	Duyo	110410	Octobe	c′10 ,	1923 _{Maryl}	and	
	and **		Usual Residence of Dec 10a. State 10b	o. County		10c. City	Town or Lo	cation						10d. Inside C	City Limits
	lanyli e de	ō	Md.	Baltim	ore		ndalk								
	28a-	ect	10e. Street and Number					10f. Zi	p Code			10g. 0	Citizen of What Cou	ntrv?	
	with the	Funeral Director	2419 Fair							21222			USA	,	
	me 2;	era	11. Marital Status		12. Was Deced		3. 13.	Was Dece	dent of His	spanic Origin? (S	Specify Yes or N	lo-	14. Race - Ameri		
ယ	of the control of the	Fur	1 Never Married	2 Marned	Armed Forc			lf Yes, spe 1 ☐ Yes			to Rican, etc.)		Black, White	_	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by	3X Widowed 4 □	Divorced	If Yes, Give Year or Date	es:		1 □ Yes	2 KN NO	Specify:			Specify: WII.	rce	
5-0	natu	Completed	15. (Specify or	Decedent's Ed	ucation de completed)		16a. Dece	dent's Usu	al Occupa	tion u <i>ri</i> ng most of wo	rking	16b.	Kind of Business/Ir	dustry	
21	ithin 96 Me	idu	Elementary/Secondary		College (1-4	or 5+)					-		Home		
	led w lygier her ti		8 yrs. 17. Father's Name (First				п	ouse	wite	18. Mother's Na			Home		
anc	be fi	Be		kowski						Helen			en Sumame)		
3	2 should be filed within and Mental Hygiene. Tie marked other then "reumatic event, the Med	1º	19a. Informant's Name/		Tuna (Print)		10h Maili	- Add	- /Ctt-				Town Chair 7	- C- d-)	
Maryland	d 2 sh th and 7 te r traur			Clement:		ghter		•		Dundall		,	or rown, state, zi	b Code)	
	1 and 2 Health tem 27 i		20a. Method of Dispositi		s uau	20b. Pla	ace of Dispo	sition (Na	me of	- 1	Date		Location - City or T	own, State	
Baltimore,	Pages nent of h ant: If its ury or of		1 XBurial 2 ☐ Cr	emation 3 🗆		ate	metery, crer Stani			May	15 2006	Ō			
Ē	int Partment of Indian		4 ☐ Donation 5 ☐ 21. Signature of Funera			DC.					ındalk	Mar	yland		
Ba	permit. Pages 1 and Department of Healing Important: If item 2 any injury or other 2006.		hath	m/1. (made	1/2 5	onne.	lly F	uneral I rs Point	Home Of	Dun	dalk		
-s.			23a. Part1. Enter the di shock, or heart fail	sease, or comp	olications that cau	sed the death.								Approxima	te
	Physician		Immediate Cause (Fina		one cause on eac	h line.	Onni	1	1	andia	nmu.	h- 1	14.		
	/Medical		disease or condition resulting in death)	-	a. Due to (or	as a consequ	ence ot).			v acce	0	104	July 1	1-23	L DU
	Examiner					Non	gry	C	RVE	ry	Unse	92	e	un-	Mown
\$ 30		Jer	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ons, diate	Due to (or	as a consequ	ence of):								
	cuted nd ransi	Examiner	triat initiated events	y)	c										
Ó,	e exe ian a urial-t	Ex	resulting in death) Last	- 1	Due to (or	as a consequ	ence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical		•	d										
89 x	ertific ling p	Physician/Medi	IF FEMALE:		00- 14										
Вох	ath c attend for us	lan/	23b. Was decedent pred in the past 12 men	gnant		n 2 ☐ Fetal	death 3[Ectopic					23d. Date of delive Month	- /	Year
P.O.	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregnar 9☐Unknow	it at time of de n	atn 5L	Other (s	респу)						
	that ti	Ph	Part II. Dther significan	t conditions of	ontributing to dea	th but not resul	Iting in the u	nderlyina	cause give	n in Part I.	23e. Did	tobacco	use contribute to t	he cause of	death?
ds,	signe d be	d by	An	emic	a .	11 .	Nen		-		1 🗆] Yes	2 No 3 Pro	bably 4 🖨	Unknown
0	w requir been si should	Completed	e	0.0.	. De		ha			<u>/</u>	24- 146		0.45 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		- Table
Rec	has be 2	mpi		<i>or</i> we) UX	70000	1 -7				24a. Wa aut	s an opsy formed?	prior to co	ompletion of o	available cause of
a	n: Th licate r, pa					•					1 ☐ Yes	201		2 0 No	
Σ	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to examiner? 1 Yes 2 No		Hospital:		- D/O :- :		Othe	26. Place of De			- 50: 10		
of	Physical distribution	1: To	27. Manner of Death		28a. Date of	atient 2 E	28b. Time o		UA	4 Vursing I	28d. Describe		6 Other (Speci	fy)	
on	ding th. Afte	tior		Pending investigation	(Month,	Day Year)	Injury	м	28c. Injury Work 1 ☐ Y	? 'es 2 ☐ No			,,		
Division of Vital Records,	Atter deal ctor y the	fica	3 ☐ Suicide 6	Could not be determined	28e. Place of	Injury - At hor	ne, farm, str	reet, factor	ry, office				and Number or Rur	al Route Nun	nber,
Ö	afor after	Certification;	4 🗌 Homicide	40.0	building	, etc. (Specify))				City or To	own, Sta	ite)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier	Certifying Ph	ysician: To the b	est of my know	vledge, deat	h occurred	at the tim	e, date and plac	e, and due to th	e cause	(s) and manner as s	stated.	
	n 24 he Fu	edical	(Check only 2 one)	Medical Exam	and manne	r stated.	on and/or in	vestigation	n, in my op	inion, death occ	urred at the time	, date a	nd place, and due t	o the cause(s	s)
	To the complete of the complet	Σ	29b. Signature and title	of certifier	110			29	c. License	number	7 5 /1	29d. D	Date signed (Month,	Day, Year)	7/
	-		1 Mis		IVER				\mathcal{D}	- >57	54	05	7-12-	200	16
1	5		30. Name and address of MALLE	of person who	completed cause	of death (Item	23а) (Туре,	Print)	0 - 0	PAI 1	RUD	,	110 2	172	1
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	Sta Registi		31. Date filed (Month, D	Y 1 6 20	006	istrar's Signat	As As	orkes							

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State legistrar	Certific	cate of D	eath		F	Reg. No.	000 1343
Physician ledical Examine		1. Decedent's Name (First, Middle, Last)	N WRIGH	7			2. Date of Dea Month May 9, 20	Day Yea	3. Time of Death 2220 hrs
	4	4a. Facility Name (if not institution, give stre Upper Chesapeake Medical C	eet and number)	4b. (City, Town, or Lo el Air	ocation of Deat	h	4c. County of Harford	of Death
Funeral Director	- 1	Social Security Number 6. Sex 200 - 70 - 8411	7. Age (In yrs. last bit		Under 1 Year Months Days	If Under 24Hr Hours Mir	_	1986	9. Birthplace (State or Foreign FE NUSY 10A+V Country)
nd show any ice.	-	Usual Residence of Decedent 10a. State 10b. County HARFORT	10c. City, Town	n or Location	T				10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Directo	10e. Street and Number Scarboro 3525 Scarboro	+ RD.	10	f. Zip Code 2115	34		10g. Citizen of Wh	nat Country?
and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygier Mental Hygier Transmire or it marked other than "natural", or items 23a or 28a-f She traumatic event, the Medical Examiner must be notified at once To Be Commissed by Ermoral Director	runeral	1 Never Married 2 Married 1	Was Decedent Ever in U.S. Armed Forces? Yes 2 No	If Yes,	cedent of Hispa specify Cuban, I	Mexican, Puerto	pecify Yes or No Rican, etc.)	White	- American Indian, Black, e, etc.
72 hours after "natural"		15. Decedent's Education (Specify only hi	ates:	. Decedent's L	sual Occupation of working life. D	n (Give kind of		16b. Kind of Bu	
nore, MD 21215-0036 ages I and 2 should be filed within 72 not Health and Marketal Hygener it. If then 27 is market other than other traumatic event, the Medical	21	17. Father's Name (First, Middle, Last)		APPR	ENTICE	Mother's Nam		Maiden Surname	·
e, MD 2121 I and 2 should be fit Health and Mental I item 27 is marked r traumatic event,		19a. Informant's Name/Relationship (Type,	Print) 18 - FATHER 3	9b. Mailing Ad	Scarboi	KIMS and Number or	Rural Ro e Nu	SCHO!	n, State, Zip Code)
₩ — ± := =	1	DALE 0. WRIGHT 20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b. Place crema	atory or other i	(Name of ceme	ii I m	A4 13.	20c. Location -	T ₁ mD 21154 City or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	meth	22. Name	and Address of	of Facility 3	NEW PUR	WHIN TOR.	FUREST HILL,
Physician /Medical	1	239 Part I. Enter the disease, or complicating failure. List only one cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause		EVAN	node of dying, su	uch as cardiac	or respiratory ar	rest, shock, or he	AIR MD 01050 Approximate Interval Between Onset and Death
Examiner		400	to (or as a consequence of):						
	mine	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of): to (or as a consequence of):						
execut an and al - tra		d	MENDED 10e,19b]	per fh	2855 5-	-16-06	vt		
68760, errificate be e. ding physiciar e as the burial	2 2	IF FEMALE: 13b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnancy			Ectopic pregn		23d. Date of Month	delivery Day Year
b. O. Box 687 that the death certific red by the attending l detached for use as the	≥L	1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions con	Unknown		(Specify)	en in Part I	23e Did	obacco use contri	bute to the cause of death?
ords, P.O. w requires that to	2							es 2 🗸 No 3	Probably 4 Unknown Were autopsy findings available
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Vital Rec ysician: The l his certificate l director, page	Ř	25. Was case referred to medical examiner?	tal: 1 Inpatient 2 V ER/0	Outpatient 3		f Death (Check	ng Home 5	Residence 6	Other.
n of V ding Plys After thi funeral d	9 :::0	1 Natural	28a. Date of Injury (Month Day Year) 28b.	Time of Injury	/ 28c. Injury		28d. Describe	how injury occurr ito involved in	ed
Division pital or Attendio ours after death. eral Director: A	ertification:	2 ✓ Accident Suicide 6 Could not be determined	28e. Place of Injury - At home,				or Town.	State)	er or Rural Route Number, City
E 5 5 7 1 €	<u> </u>	29a. Certifier (Check only) Certifying Physician:	(Specify) Local Street To the best of my knowledge, de the basis of examination and/or				d due to the cau	se(s) and manner	
To t To t com	Med		manner stated		29c, License	number		29d Date sign	ed (Month, Day, Year)
		30. Name and address of person who comp	pleted cause of death (Item 23a))	O.C.M	.E.		May 10, 20	006
7			ef Medical Examiner		Street, Baltir	more, MD 2	1201		
Stat Registra	~	31. Date filed (Month, Day, Year) MAY 1 6 2006	32 Registrar's Signature	Jones .	à la la la la la la la la la la la la la				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month BERNARD 8.140 AM WAJER 06 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE MARIS HOSPICE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Hours Days 213 09 8975 1 3 M 2 F Months 3 Yrs. MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State BALTIMORE 1 Yes 2 No MO BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2816 USA 21234 ENDALE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 TNo Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALES SEAFOOD ATLANTIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A BINCOUN MD XI A. WAJER CI. - SON KOSERT 1000SBURY 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) STANISLAUS 21. Signature of Funeral Service Licensee 8800 HARFORD 22. Name and Address of Facility PARKUITE, MO 21254 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of). IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Certification:

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item 27 le marked other then "naturel", or iteme 23a or 28a-f ehov other treumatic event, the Modical Examinar must be notified at

al Hygiene.

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Department of Importent: If eny injury or once.

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Pages

death with the Maryland

21215-0036

Maryland

1 Yes 2 No 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29b. Signature and title of certified 29c. License numbe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year) State



DHMH 17 Rev 1/2001

Registrar

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

			1 - For State Registrar	State of Marylar		artment <i>rtificate</i>			Mental Hy	rgiene	06	15437
			Decedent's Name (First, Middle, Last	t)					2. Date of De	eath	Vana	3. Time of Death
	Physici /Medio		ROBERT SAWYER	WILHELM, SR					Month	12 2	Year	11321PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or l	ocation of De	ath	4c. County		
			Franklin Square			1508		ile		Bai	time	ore
	Funeral Director		212 30 2120	7. Age (In yrs	last birthday) Yrs.	If Under 1 Months	Year Days	Hours Mi	n. Oct. 2	^{rth} Year 939	9. Birthi Coul Ma	olace (State or Foreign ntry) ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					T	10d. Inside City Limits
	Be-f eho	ector		timore	Pa	rkvil						1 ☐ Yes 2X No
	th with ti	Funeral Director	10e. Street and Number 9101 A Simms A	venue		10f. Zip C		234		10g. Citizen of V	What Coul	ntry?
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. od other then "neturel", or Iteme 23e or 28e-f ehow event. The Medical Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 2	y Cuban	panic Origin? , Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		ck, White,	can Indian, etc. White
5-0	72 h	etec	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual	done du	ion ring most of w	orking	16b. Kind of B	usiness/in	dustry
21	ithin ne. hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use Truck	retired)	•		Teamst	ters	Local 355
2	led w lygier her ti		1.2 17. Father's Name (First, Middle, Last)			11 uck			ame (First, Middle	14-74 0		
Maryland	should be find Mental he marked of	To Be	Gorman Wil	helm, Sr.					Sawyer	, Maiden Surnan	ne)	
	nd 2 lith a 27 to		19a. Informant's Name/Relationship (T Elaina Wilhelm-	,, ,					Rural Route Numb ue,Park			and 21234
Baltimore,	Pages 1 aunent of Hearunt: If item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Removal from State EV	Place of Dispondent Commerce of Dispondent Co	rera1°°		b1 5-	Date 16-06	20c. Location -	-	own, State 1,Maryland
Balti	permit. Pages Depertment of Importent: If it eny injury or o		21. Signature of Funeral Service Licens	- tadden			Address	of Facility Ev	ans Char Parkvill	el Of Me e,Maryla	emori and 2	es 1234
8760, <	Physician //Medical Examiner projection and project	al Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End Stage Due to (or as a consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or according to the consect Due to (or ac	quence of): Quence of): Quence of):	gdise		wit	Sever)	Approximate Interval Between Onset and Death
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۵.	8 20 60	þ	Part II. Other significant conditions co	ontributing to death but not re-	sulling in the u	nderlying cau	se given	in Part I.	23e. Did	/		ne cause of death?
Division of Vital Records,	taw requas been 2 should	Completed							24a. Was			psy findings available mpletion of cause of
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/ita	Physicien: r this certition ral director,	Be (25. Was case referred to medical examiner?				T -		eath (Check only			
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ΟĬ	tal or At s after c el Direct ed in by	Certification:	4 Homicide determined	28e. Place of Injury - Al h building, etc. (Speci	ome, farm, str fy)	reet, factory, o	office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	il Route Number,
	To the Hospital or Attending Physicien: The law requir within 24 hours after death. To the Funeral Director: Atter this certiticate has been si completely filled in by the funeral director, page 2 should	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of my kn iner: On the basis of examin- and manner stated.	owledge, deatl ation and/or in	h occurred at vestigation, in	the time	, date and place nion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	inner as st and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	11.			icense	number		29d. Date signed	3	Day, Year)
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	5		30. Name and address of person who o	ompleted cause of death (Ite	m 23a) (Type,		اررا					
			DR. Anthony M	uchard 900	OFran	KliNS	29111	are Dr	ive Ba	Himore,	Md	21237
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 200	32 Registrar's Sign	ature	0.0	C					
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DHMH 17 Rev 1/2001

Withelm, Robert

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 8:05 PM **Physician** 10 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death give street and number) Examiner Baltimore owson MOME 7. Age (In yrs. last birthday) Yrs. Year If Under 24 Hrs. If Under **Funeral** Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State Tiles ville 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21208 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2 No Yes, Give 1□Yes 2XNo ö Baltimore, Maryland 21215-0036 Specify: Specify: 161ac þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Give kind of work done during life. DD NOT use jetired) 15. Decedent's Education fy_onfy highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) ads Name (First, Middle, Last) 18. Mother's Name (First, Be ee ite Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition 1 🗆 Burial 3 Removal from State Cremation 5 Other (Specify) 4 Donation 21. Signature Furter I Service Lice al Services alstown, ma 21133 1 berty 23a. Part1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1FTYes 2□No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 No 1 Yes ours after death.

Neral Director: After this certifical filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Specify) HC5P1C€ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MAy 11,2006 5000 30. Name and address of person who completed cause of death (I)em 23a) (Type, Print) GEOI N. CHARLES JTREET / OWSON 31. Date filed (Month, Day, Year) Registrar's Signature State 6 2006 Registrar

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			1 _ State	State of Mary		artment of i rtificate of				13 C C C	151.39
	. AC 88).		Registrar	*1		runcate of	Deam		Date of Death	. NE. UUU	1 0 9 0 0
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	/Medic		Genevieve	Virginia	- WMT				WAY	10 200	7
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ر دون			5. Social Security Number 6. Se		yrs. last birthday)		If Under		Date of Righ	NIA	
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	Mar	ţō	MD Anne Aru	nde1	Glen Bu	rnie					1 ☐ Yes 2 ☐XNo
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	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of I	lispanic Orig	gin? (Specify		14. Race - Ап	
စ္	after or its	교	1 ☐ Never Married 2 🔀 Married	1 Yes 2 XNo		1 ☐ Yes 2 X No			arr, 6tc.)	Black, Wh	
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ر ا	72 h	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	oation during most	t of working	16	b. Kind of Busines	s/Industry
2	Althin hen hen	du	Elementary/Secondary (0-12)	College (1-4or 5+)			d)				
7	be filed within 72 hours after death with the Maryland Ital Hygiene." Id other than "natural; or itame 23a or 28s-f show event, the Medical Examinar must be notified at		17. Father's Name (First, Middle, Last)		Homer	maker	40 14-15-		Local Adiabatics Ada	Own Hom	le
anc	tall he fi	Be	Wilbert Leroy Welk							iden Sumame)	1-
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene." Important: if item 27 ie marked other than "natural", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Exerciner must be notified at once.	2	19a. Informant's Name/Relationship (T)		405 M-11					eth Rohrb	
Ma	d 2 si th an 7 le r traur									City or Town, State,	
	1 and Health am 27 ther tr		Mr. Dewey R. White 20a. Method of Disposition	,Sr. /nuspai	Ob. Place of Dispo cemetery, crei	Clear Dr	op Ct	#10		n Burnie, c. Location - City o	
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Baltimore,	it. Partme		4 □ Donation 6 □ Other (Specify) 21. Signature of Full 11 □ Lichns		Meadowrid			5-13-2		kridge,	
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			mock, or heart failure. List only o	ne cause on each line.			_		opiratory arros		Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	d. 23c. If yes, outcome of pn 1	regnancy Fetal death 3	other (specify) nderlying cause grant 3 DOA	26. Place Der: 4 Nui Yat K? Yes 2 N The, date and pipinion, deat	of Death (Chrising Home 28d. No 28f. I	24a. Was an autopsy performe 1 Test only one) 5 Residence Describe how Location (Stree City or Town, 3 due to the cause to the cause to the time, date	Month 2 No 3 F 24b. Were a prior to death? 1 Ye 26 6 Other (Sp. injury occurred at and Number or F at and place, and du Date signed (Mon	Day Year to the cause of death? Probably 4 Unknown sutopsy findings available completion of cause of s 2 No Pocify) Bural Route Number, stated. e to the cause(s)
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Baltimore, Maryland 21215-0036
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23e or 28e-1 show any injury or other traumatic event, the Medical Establishments be neithfind at some.

Beatrice Waxman

Uthert known as

Pnysician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

1	1 - For State Registrar	State of Maryland		artment of H		and Me		jiene jeg. No.	006	15440
	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
n al	BEATRIC	E	W	NAMXA			may	10	200	6 2123 PM
r	4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, or		of Death		4c. Co	inty of Dea	
	Singi Hospital	of Baltmorn	e	Baltin	. 4	04.11==				N/A
	5. Social Security Number 6. Sex 10-10-10-10-10-10-10-10-10-10-10-10-10-1	7. Age (In yrs. la	ast birthday) Yrs.	if Under 1 Year Months Days	ff Under Hours	Min.	8. Date of Birth Month, Day 09/26	/ 1019	9. Bir	thplace (State or Foreign ountry)
	Usual Residence of Decedent	Λ 00					09/20	/ 1313		TID
	10a. State 10b. County	10c. City	, Town or Lo	cation						10d. fnside City Limits
ž	MD N/A		BALT	IMORE						1 X Yes 2 □ No
)Ire	10e. Street and Number			10f. Zip Code				l0g. Citizen	of What C	•
<u>a</u>	6711 PARK HEIGHTS	AVENUE #201			2121					USA
by Funeral Director		Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Ori n, Mexicar	gin? (Spec n. Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Ami Black, Whi	erican Indian, te, etc.
Ϋ́	1 ☐ Never Married 2 ☐ Married 3 Midowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No ff Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Spi	ecify:	WHITE
ed	15. Decedent's Educa		16a, Deced	dent's Usual Occupa	ation			16b. Kind o	of Business	/Industry
Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring mos	t of workin	g			,
E	Elementary/Secondary (0-12)	College (1-401 5+)	SECRI	ETARY				ACCO	UNTIN	G
Bec	17. Father's Name (First, Middle, Last)		-12				(First, Middle,	Maiden Sur	name)	
0	NATHAN		BAKE	₹	IDA	١				F00R
1	19a. Informant's Name/Relationship (Typ			ng Address (Street				•		
1	MODELIN BUILDON /	DAUGHTER		FALLS GA	RLF L		#J - BA			D 21209
	20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Re	amoval from State	emetery, cren	sition (Name of natory or other place						Town, State
	4 □Donation 5 □ Other (Specify)			OH CEMET			_		DLÁWN	
	21. Signature of Funeral Serfice Licentee	ئر		Name and Address			L LEVIN ROAD -			., INC. , MD 21208
	23a. Part1/Ent - the disease, or compfice shock, or heart failure. Li Honly one	ations that caused the death	. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	fmmed ate Cau e (Final disease or condition resulting in death)	Due to (or as a consequ	an x	ailure						Onset and Death
		0 .		bolism						
ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):	NO 013111						
Examine	cause. Enter Underlying Cause (Disease or injury that initiated events									
EX	resulting in death) Last	Due to (or as a consequ	ience of):							
ca	d.									
Med	IF FEMALE:									
an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy				23d.	Date of de	livery Day Year
\ <u>S</u>	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5	Other (specify)			<u></u>			549
Ę	Part II. Other significant conditions cont	tohuting to death but not resu	ulting in the u	nderlying cause give	an in Part I		23e Did to	bacco use	contribute t	o the cause of death?
Completed by Physician/Medical	Pulmonani Luper	APO 61' 0-0	ming in the di	idonying oddso givi	on any anti-	•	1 🗆 Y	_/	4	robably 4 Dunknown
etec	- Tourist Holy									
E E							24a. Was a autop	sy	prior to death?	utopsy findings available completion of cause of
္ဌ	OF Man ages referred to Todical				20.5:		1 ☐ Yes	2 1 No	1 🗆 Yes	2 12 No
Re	25. Was case referred to medical examiner?	ospitaf: 1 ☑ Inpatient 2 ☐ E	ER/Outpatien	• all post Othi	N F		(Check only or	-	O+h /O	
- - -	27. Manner of Death	28a. Date of fnjury (Month, Day Year)	28b. Time of	I 3 DOA	4 L NL		ne 5 Resid 8d. Describe h			reny/
<u>i</u>	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		c7 Yes 2 🗌	No				
<u>2</u>	3 Suicide 6 Could not be determined	28e. Place of fnjury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		2	8f. Location (S City or Tow		umber or A	ural Route Number,
Cer	4 - Homedo	building, etc. (Specify	7				City of 10W	ri, State)		
Medical Certification; To	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or in	occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, a th occurre	nd due to the o	ause(s) and late and pla	d manner a ce, and du	s stated. e to the cause(s)
Me	29b. Signature and title of certifier			29c. License	number		- 2	9d. Date si	gned (Mon	th, Day, Year)
	b Whenra Show	e		RE	5-0	00		Mai	10,	2006
	30. Name and address of person who con	npfeted cause of death (Item OKAGBUE, N		Print) SINAT HO.	PITA	1 04	BALTI	MORE		
е	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture			-				
ır	MAY 1 6 2006	Blocker St.	Spare		_					
11										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/200

12

Sta Registr

4c. County of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUSTIN Month 05/4 JOSEPH

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

in		4	University of Mary	yland Med	lical Cent	er Ba	altimore			N/A	
I	Funeral Director		462-17-0944	Sex 7.	Age (In yrs. last birt.	hday) If Under Months		Ain. (Month, Da)	8,1964	Cour	place (State or Foreign ntry) RG/W/A
	pur »		Usual Residence of Decedent 10a, State 10b, County		100 City Town	as Lagation					
	hours after death with the Maryiand turel', or Items 23a or 28a-f show at Exscrimer must be multing at	5		1 / 4	10c. City, Town			2 0	,	1	10d. Inside City Limits 1 XYes 2 No
	Ne M	Funeral Director		JIA		13	ALTIMO Code	RE CI	TY		
	vith t	吉	10e. Street and Number	-n		10f. Zip	Code		10g. Citizen of	What Cour	ntry?
	ath v	ā		ET RO			212			SA.	
	er de	E I	11. Marital Status	12. Was Decede Amed Force	s?	13. Was Deced If Yes, spec	ent of Hispanic Origin's fy Cuban, Mexican, P	(Specify Yes or No- uerto Rican, etc.)	14. Rad Bla	ce - Americ ick, White,	
30	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 21 If Yes, Give Year or Date		1 ☐ Yes 2	No Specify:		Specif	ry: n.	. 0 16
2-003p	hou	ed	15. Decedent's E			Decedent's Usua	LOccupation		10h Kind of D	1011	4CK
0	n ne	plet	(Specify only highest gra	ide completed)		(Give kind of wor life. DO NOT us	k done during most of e retired)	working	16b. Kind of B	usinessin	dustry
7	filed within 72 Hygiene. ther than "na ther the Medic	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		TATION W		SANIT	TATI	ON Co.
2	othe othe	BeC	17. Father's Name (First, Middle, Last,					Name (First, Middle,			7.1007
and	Aenta Aenta rked rlc e	ToB	LENWOOD		AUST	IN	IN	A	/	WAI	$R\Lambda$
a	short and N		19a. Informant's Name/Relationship (Type, Print)			(Street and Number or				
Ξ	alth alth a		IDA LAMPKIN	1 (MO)							
e je	of He of He roths	1	20a. Method of Disposition		20b. Place of	Disposition (Name, crematory or of	INSET RI	Date	20c. Location	- City or To	own, State
Ĕ	Page nent c nt: If		1. Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		KING	MEM	PARU 5	-18-06	112000	1 4-11	WMA
Dallimo	mit. pertra porta / inju		21. Signature of Funeral Service Lices	is etc.	171765	22. Name and	Address of Facility	RAWELL TR	ECINE	RAI	HOME
۵	8 9 E 8	9	MA	V) · V E		2036	Address of Facility B. FULTE	AVE C	4100	MA	21217
¥.	Ş		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the death. Do no	ot enter the mode	of dying, such as care	diac or respiratory arr	est,	10	Approximate
	Physician		Immediate Cause (Final disease or condition			• . 1	a 1				Interval Between Onset and Death
	/Medical		resulting in death)	a. TULLTD Due to (or	LE INJURIO as a consequence o	es_with_ f):	Complicati	ons	-)	
	Examiner			_					MX		
v.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequence o	i):	X	0 0.	7./		
	cuted	Examin	Cause (Disease or injury that initiated events	c				I WEDICAL E	LAMINA		
ĵ	exe en ar rial-t		resulting in death) Last	Due to (or	as a consequence of	f):		ROVED			-
9	ate be aysici	Physician/Medical		d	-		CATON CATON	ROVED WEDICAL E		To.	
Ö	ng ph ng ph as t	Med	IF FEMALE:								
5	th ce	an/l	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2 Fetal death	3 □Ectopic pre	agnancy			ite of delive	•
	e dea	Sici	in the past 12 months? 1 Yes 2 No		at time of death	5 Other (spe			Mo	onth	Day Year
	d by t	F.	9 Unknown								
Ŝ	igner bed	þ	Part II. Other significant conditions of	ontributing to death	but not resulting in	the underlying ca	use given in Part I.				ne cause of death?
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נ	as b	ed l						24a. Was a autops		Were autor	psy findings available inpletion of cause of
	The page	Complete						perform	ned?	death?	_
2	ertification:	Be (25. Was case referred to medical examiner?				26. Place of [Death Check only on			
	hysi his c	္	1 X Yes 2 □ No	Hospital: 1 Inpa	atient 2 ER/Outp	patient 3 DOA	Other: 4 Nursin	Home 5 ☐ Reside	ince 6 🗆 Oth	er (Specify	1)
-	ing P	ë	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Ir (Month, L		me of 28 ury	lc. Injury at Work?	28d. Describe ho	w injury occurr	red	
2	leath leath tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be			nown M	1 ☐ Yes 2 No	Subject	fell or	ıt of	a tree.
2	or At fter d irect n by	Certification;	4 Homicide determined	286. Place of	Injury - At home, farr etc. <i>(Specify)</i>		office	28f. Location (St City or Town	reet and Numb	er or Rura	Route Number,
2	urs a		V V	N	Yaı			Baltimor	e. Mary	rland	
	Hosp 24 ho Fune tely fi	edical	29a. Certifier 1. Certifying Ph (Check only one) 2 ☐ Medical Exert	pier: On the basis	or examination and	death occurred a or investigation, i	t the time, date and pla in my opinion, death or	ce and due to the co	auso(s) and ma	annor ac ct.	ated. the cause(s)
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title of certifier	and manner	stated.		License number				
	E ₹ 5		and the Granting	//_					9d. Date signed	ı (Monta, L	Jay, rear/
	0		1///				1006029	. 7	5/12/1	06	
1) 1		30. Name of address of person who	completed cause of	A	ype, Print)	1006029 - Balti	131 CL A N.A	1) 212	, ,	
	Sta	e.	31. Date filed (Month, Day, Year)	32. Reais	5 Grestrar's Signature	eve It	- Varn	miche joi	1) 2(2	-01	
	Ota	-		100							

DHMH 17 Rev 1/2001

Registrar

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DHMH 17 Rev 1/2001

KNOWN AS

			For State Registrar	State of Ma	aryland / De <i>C</i>	partment ertificate				F	Reg. No.	06	15443
ı	Physicia	an	1. Decedent's Name (First, Middle, Last AUSTIN ANTO	-						Date of Dea Month NAY 1		Year	3. Time of Death 8:30A M
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, T	Town, or Lo	ocation of De	1	MI			
1	LAGITIII	C.	18 MALUS COUF			GV	NNYN	OAK			BAL	Day Year 3. Tire 2006 8 4c. County of Death BALTIMORE Sear) 9. Birthplace (Single Country) 1940 TRINII 10d. Inside Country? USA 14. Race - American India Black, White, etc. Specify:BLACK 3b. Kind of Business/Industry T. AGNES OSPITAL Inden Sumame) S City or Town, State, Zip Code) MD 21207 1c. Location - City or Town, State ATONSVILLE, NERAL HOME 2 E., BALTIMOF 1. Appropriate to the cause of the c	RE
	Funeral		5. Social Security Number 6. S	ex 7. Ag DXM 2□F	e (In yrs. last birthda	Months		If Under 24 H Hours M	1rs. 8. I	Date of Birt Month, Day	h y. Year)	Cou	place (State or Foreign intry)
	Director		501 – 62 – 8297 Usual Residence of Decedent		65 Yrs					11/24	1/1940	TR	INIDAD
	yland now		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	e Mar	ctor	MD BALTIN	IORE	GWYN	N OAK							1 ☐ Yes 21⁄2 No
	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28a-f ehow he Medical Examiner must be nutified at	by Funeral Director	10e. Street and Number 18 MALUS COUF	?Т		10f. Zip		207			•		intry?
	ms 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decede			(Specify	Yes or No-		ce - Ameri	
9	or ite	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2♥ I If Yes, Give	No	1 Yes 2		Specify:	Jeno mica	iri, etc.)			
21215-0036	hours tural',	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		cedent's Usual	I Occupation	on					
215	in 72 in "na Wedic	Completed	(Specify only highest gra	de completed) Colfege (1-4or 5	(G life	ive kind of worl e. DO NOT us	k done dur e retired)	ring most of					
212	filed with Hygiene other the	Com	12TH	2 YEARS	RA	DIOLOG							
Maryland	ges 1 and 2 should be filed within 72 hours after deeth with the Marylan tof Heeth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other treumatic event, the Medical Examinar must be notified at	To Be (17. Father's Name (First, Middle, Last) MCKENZIE ANTO			П	1/			st, Middle,		ne)	
	and 2 sho leeith and I m 27 is ma		19a. fnformant's Name/Relationship (JOCELYN ANTOIN										p Code)
Baltimore,	Pages 1 and nent of He and the frem ant: If item arry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)		20b. Place of Discemetery, of METRO	crematory or ot	ther place)	5/	Date 17/0	6		-	
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Fujeral Service Licer	See .	our								
,760,	Physician /Medical Examiner philal-Itausit philal-Itausit	ical Examiner	23a. Part / Enter the dispase, or common show, or heart failure. List only Immediate Cause (Final disease or condition resulting for death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence of):								Interval Between Onset and Death Yman Hus
P.O. Box 687	The law requires that the death certificate is the has been signed by the ettending physi bage 2 should be detached for use as the bage 2.	Physician/Medic	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death	3 □Ectopic pre 5 □ Other (spe							
	uires that signed b	þ	Part II. Other significant conditions	ontributing to death b	out not resulting in th	e underlying ca	ause given	in Part I.		23e. Did to	•		the cause of death?
Records,	hysician: The law requir nis certificete has been si I director, page 2 should I	Completed								24a. Was autop perfo 1 Yes		prior to co death?	opsy findings available ompletion of cause of
Vital	cian: ertific ector,	Be	25. Was case referred to medical examiner?					26. Place of I	Death (C	neck only o	ne)		
of	Physician: this certific ral director,	. To	1 ☐ Yes 2 ♣No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpa			4 🗀 INUISIII					(fy)
O	ding After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Inju	ry M	8c. Injury a Work? 1 ☐ Ye	s 2 No	200.	Bosonibo	iow injury cood		
Division	al or Attendi after death. I Director: A d in by the fu	ertifica	3 Suicide 6 Could not be determined	e 28e. Place of Inj	jury - At home, farm, ic. (Specify)	street, factory,	, office		28f.	Location (S City or Tox		ber or Rur	al Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical Certification:	29a. Certifier (Check only one) Certifying Pt 2 Medical Example	ysician: To the best niner: On the basis o and manner st	of examination and/o	eath occurred a r investigation,	at the time, in my opin	, date and pl	ace, and occurred a	due to the t	cause(s) and m date and place,	anner as and due to	stated. to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	0 - 0 4			License r						
	6		· Ju	me	-	1)431	3 <			May 1	6, 2	006
į	(30. Name and address of person who Steven miller	1030 6	reene Tr	e rd	K13	7	Balt	0. ~	10 21	805	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 7 20	C6 32 Registr	rar's Signature	and							

DHMH 17 Rev 1/2001

06-03046 Alston, Pierre

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day Month 1310 hrs Medical Examiner Pierre T. Alston May 5, 2006 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3620 Edmonson Ave Balimore If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Davs Min Director Hours 1 X M 2 Yrs Country) 215-96-4918 26 04-05-1980 MD Usual Residence of Decedent 10b. County any 10a. State 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No 28a-f show more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. , or items 23a or 28a-f shor must be notified at once. MD NA Baltimore Director 10e. Street and Numbe 10a. Citizen of What Country 4310 Bowers Avenue Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced Specify: Bl'ack tem 27 is marked other than "natural", traumatic event, the Medical Examiner Ş 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pierre Alston Taymarnee Jamerson 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Taymarnee Jamerson/Mother 4310 Bowers Avenue Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State t: If i crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Pages
Department o
Important: I Mt. Zion Cemetery 05-11-06 Lansdowne, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Balto, MD 21217 Livella 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Gunshot wound of head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical signed by the attending physician a be detached for use as the burial -UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate been 24 hours after death.
 E Funeral Director: After this certificate has been signed by the attending physicial rely filled in by the funeral director, page 2 should be detached for use as the burns. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene ၉ 1 🗸 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? 1 Natural FOUND: Subject was shot Yes 2 🗸 No Pending May 5, 2006 1300 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 3620 Edmonson Ave, Baltimore, MD determined (Specify) Vacant Building 4 V Homicide 29a. Certifier To the Fun Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E. May 6, 2006 au, mis 30. Name and address of person who completed cause of death (Item 23a) d Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signat State 2006 MAY

DHMH 17 Rev 1/2001 OCME 2006

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:05aM Vincent Joseph Beccio May 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care of Old Court Randallstown **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Director 218-26-1692 75 May 18,1930 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location ehow 10d. Inside City Limits in then "natural", or iteme 23s or 28s-f ehover the Medical Exeminer must be notified at 1 ☐ Yes 21 No Maryland Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3201 Cambridge Drive 21244 IISA filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2⊠No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2K No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) i. Pages 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic even Be Thomas Beccio Mary Vecera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dunn 3201 Cambridge Drive; Baltimore, MD 21244
of Disposition (Name of Date 20c. Location - City or Town Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ortment o Meadowridge Mem. Park 5/18/2006 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. M01290 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Peripheral ussender disease /Medical Due to (or as a consequence of): Examiner 0 hronic BESTUCTURE PUlmonery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Chronic Anemo Box 68760, Physician/Medicai angnana ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o been signed by the should be detached 9□ Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performed Division of Vital 1 Yes 2 No . After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled In by To the Hoepital or A within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30115 5/16/6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5311 old Ct Rd Randellstown mo 21133 () hlukpehai imo 31. Date filed (Month, Day, Year) MAY 1 7 2006 32 Registrar's Signature

State

Registrar

Ol Report

			1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygier	4000	15446
Sag	Physici /Medic		1. Decedent's Name (First, Middle, Lass	Brown)	2. Date of Death Month	Day Year 7 2006	3. Time of Death 6 50 A M
	Examir		4a. Facility Name (If not institution, give 2511 WesT L	street and number) ombard Street	4b. City, Town, or Location of Deat Baltimore	h	4c. County of Death	
	Funeral Director		215020681	74 000/2	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	. 8. Date of Birth (Month, Day, Yes	9. Birthpla Country 945 MAR	ace (State or Foreign
	Maryland -I show	tor	Usual Residence of Decedent 10a. State 10b. County MARIJAIA	10c. City, Town	n or Location BALTIMORI	Editu	10	d. Inside City Limits 1 X Yes 2 □ No
	with the	Direc	10e. Street and Number	OMBARD STRE	10f. Zip Code	flog.	Citizen of What Count	ry?
5-0036	72 hours after death with the Maryland "natural", or itema 23a or 28a-f show idical Examiner must be notified at	by Funeral Director	11. Marrial Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 Yes 2 🖾 No Specify:	-	14. Race - America Black, White, e	
21215-0	filed within 72 ho Hygiene. sther than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation 16a. de completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of worlife. DO NOT use retired) HOMEMAKE	rking	Kind of Business/Indu	
Maryland 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, ILE M.	To Be C	17. Father's Name (First, Middle, Last) JOSEPH	BRU		me (First, Middle, Maid		o N
	es 1 and of Health I item 27 r other tr		19a. Informant's Name/Relationship (1) LBRA 5 mm 20a. Method of Disposition 1 Burial 2 Cremation 3	CDAUGHTER 5 20b. Place of cemeter	Mailing Address (Street and Number or R) 5 10 FERN PARK Disposition (Name of y, crematory or other place)	AVE, BAL Date / BAL 20c.	Location - City r Tow	D. 21207 vn, State
Baltimore,	permit. Page Department. Important: II any injury o		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		22. Name and Address of Facility 212 Joseph H. Brown		n Avenue 1	MD 21217
大学 一	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a	not enter the mode of dying, such as cardial to the mode of dying, such as cardial to the control of the contro	of or respiratory arrest,	1 1	Approximate Interval Between Onset and Death
ox 68760,	The law requires that the death certificate be executed the been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Exar	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence of d. 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	of): 3 □Ectopic pregnancy		23d. Date of deliven	,
P.O. B	that the deal ed by the att detached fo	hysicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Month D	Day Year
	w requires that been signed should be det	by	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the	
al Records,		Completed				24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
of Vital	Physician: this certific al director,	To Be	1 105 2 100	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou		ath Check only one lome 5 Thesidence	6 ☐Other (Specify)	
Division (ding After funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T (Month, Day Year)	ime of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred	
Divi	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certifle	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		City or Town, Sta		
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	rsicien: To the best of my knowledge iner: On the basis of examination and and manner stated.	, death occurred at the time, date and place Dor investigation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as stai nd place, and due to t	ted. he cause(s)
	with To t com	W	29b. Signature and title of certifier	Claudly	MD 29c. License number D4.14-06	29d. C	Date signed (Mogtin, D.	2006
3	1		MADHU CHA	ompleted cause of death (Item 23a) (UDITRY 6569	TYPE Print) PRINT CHARLE	ES STRI	HO 21	204
The same	Sta Registr	100	31. Date filed (Month, Day, Year) MAY 1 7 200	Registrar's Signature	Coll			

	1	John	Brow	'n				2. Date of Month Febru		3,2006 Year	3. Time of Dea 12:00 Pl
/Medical Examiner		a. Facility Name (If not institution, give	street and number	r)	4b. City,	Town, or	Location of D			. County of Dea	
	ı	Washington Adven	tist Hosp	ital	Hyat	ttsvi	ille		Pr	cince Ge	eorges
ineral rector		723 07 7173	ex 7. A	kge (In yrs. last birth	day) If Under Months	r 1 Year Days	If Under 24 Hours	Hrs. 8. Date of Month, Nover	Birth Day, Year) ber (1923 9. Bir Co Nort	thplace (State or Fo ountry) h Carolii
× =	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Li
tor for	ē	District of Columb	oia	Washing	ton						¥∏Yes 2[
If item 27 is marked other then "naturel", or items 23a or 28a-f show or other treumatic event, the Medical Exert destruction to the retified at. To Be Completed by Funeral Director		10e. Street and Number 2300 Good Hope Rd			10f. Zip					izen of What Co	
items 2:		1. Marital Status 1 □ Never Married 2 ★ Married	12. Was Deceden Armed Forces	t Ever in U.S. ;?]No 1944 —	13. Was Deced	dent of Hi cify Cuba	ispanic Originî n, Mexican, Pi	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
turel', or	2	3 Widowed 4 Divorced	If Yes, Give Year or Dates	1946	1 Tes		Specify:		1ch K	Specify: B	
t, the Medical E	- Pict	(Specify only highest gra	de completed) College (1-4or		Give kind of wo ife. DO NOT us	ork done d se retired,	during most of	working		TRAK Rat	
Con the	5	Eleventh			[1 Hand]	ler				epany	LILUUU
7 is marked other then " freumatic event, the Mer To Be Comple	ם כ	7. Father's Name (First, Middle, Last) Chester Brown						Name (First, Midd Lsha Danc	lle, Maiden		
27 is ma treuma		19a. Informant's Name/Relationship (7 Lucille Mercer Br					and Number o	Rural Route Num	nber, City o		
or other	4-	20a. Method of Disposition 1 Durial 2 Cremation 3	Removal from State	20b. Place of Cometery,	isposition (Nan crematory or o	me of other place		Date ruary 14	20c. Lo	ocation - City or	
importent: I any injury o once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Quantic	22. Name an		20	06	Tria	ngle. Von Funer	/irginia
E 8 3	1	1 Ceginald	E COL	leer	1661 Gc	ood E	lope Rd	SE, Was	hingt		
ician edical		23a. Part 1. Each the disease, or com, shock, heart failure. List only disease or candition resulting in death)	a. Acute R	ed the death. Do no line. enal Fail s a consequence of	ure	le of dying		tx!			Approximate Interval Between Onset and Dea
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burial-transit	4	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	Renal Fa s a consequence of s a consequence of	ilure			MA TANANTA BY	NEDICAL EVAN	MER	
physicia the bur dical		nat initiated events	Due to (or as	s a consequence of	ilure		CERTIFIC	WINN WEST OFFICE BEILD	NEDICAL EXA	MMER.	
physicia the bur dical		resulting in death) Last	Due to (or as d	s a consequence of	ilure			WA WA		23d. Date of del Month	*
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		1 - For State Registrar	State	of Ma	ryland				lealth a D <i>eath</i>	ind M	ental		ene g. No.	06	15448
Physici	v.	1. Decedent's Name (First, Middl	e, Last)								2. Date Mont	of Death	Day	Year	3. Time of Death
/Medic		Brenda	Joyce	Banl	ks						May	12	2006		2:42p. M
Examin	er	4a. Facility Name (If not institution		number)					Location of	f Death				y of Death	
riving a second	10 m	3308 Ludgate F 5. Social Security Number	COAC 6. Sex	7 Age	(In yrs. ias	t hirthday)		Balt:	imore	4 Hrs.	8. Date	of Righ	N	/A	place (State or Foreign
Funeral Director		218–42–1835	1 ☐ M 2 🔀 F		62	Yrs.	Months		Hours	Min.	(Mont	h, Day,	Year)	Cour	ntry)
STATE OF THE PARTY		Usual Residence of Decedent												1110	
urylan show	_	10a. State 10b. County	NT /A			Town or Lo								1	Od. Inside City Limits
388-1 s	Director	MD	N/A		Dal	timor									MXYes 2□No
with the	Dire	10e. Street and Number 3308 Ludgate	Road				10f. Z	ip Code 212	215			10	g. Citizen of	What Cour SA	ntry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene Hygiene insture!; or items 23s or 28s-f show ent, the Madical Examinet must be notified at	Funerai	11. Marital Status	12. Was De	acedent Fr	ver in ILS	13 V	Vas Dec		Ispanic Orig	in? (Spec	cify Yes	or No-		ce - Americ	an Indian
fter d	Fun	1 ☐ Never Married 2 ☐ Marri	Armed	Forces? s 2. √ No		ł	f Yes, sp	ecify Cuba	in, Mexican,	Puerto F	Rican, et	3.)		ick, White,	
ours a	þ	3 ☐ Widowed 4 € Divorced	If Yes, Year o	Give Dates:		1	I ∐ Yes	2 ½ No	Specify:				Speci	hy: Bl.	ack
72 ho	Completed	15. Deceden (Specify only highe	t's Education st grade complete	d)		16a. Deced (Give	kind of w	ork done o	during most	of workin	ng	1	6b. Kind of E	Business/In	dustry
f within jiene. r then	idi	Elementary/Secondary (0-12)		(1-4or 5+	+)			use retired	,				.		
filled v Hygie ther i	ပို	12th 17. Father's Name (First, Middle,		I/A		Fact	ory	Worke		r's Name	(First, M	iddle, M	Facto aiden Sumai		
id be ental ked o	To B	Walter Fax							Ge	rald	ine		Hall	·	
should and Mer marke umatic	-	19a. Informant's Name/Relations	hip (Type, Print)			19b. Mailin	g Addre	s (Street a	and Number	r or Aural	Route N	lumber,	City or Town	, State, Zip	Code)
and 2 ealth a n 27 is		Shawnta Banks	- Daught	er		3308	Lud	ate	Road	Ba1	to,	Md	21215		
of He of He fiten	1	20a. Method of Disposition 1	3 □Removal fro	m State	20b. Plac cem	e of Dispos etery, cren	sition (Na	ime of			ate		Oc. Location	- City or To	own, State
Pages ment of ant: if it ury or o		4 ☐ Donation 5 ☐ Other (S	pecify)		King	g Memo	oria	1 Par	k 5	-17-	2006	R	landal:	1stow	n, Md
permit. Pages I and 2 should be filed with Department of Health and Mental Hydrene filed with Important: If item 27 is marked of ther the sny injury or other traumatic event, the MODEs.		21. Signature of Funeral Service	Licensee	li se	011	22	. Name a	and Addres	ss of Facility	1		43	800 Wal	bash .	Avenue
0.02.00	. ,	23a. Pari 1. Enter the disease, or	0,4	MI)	VIX.				ERAL H				ltimo	re, M	D 21215 Approximate
Physician /Medical Examiner		flock, or heart failure. List Imprediate Cause (Final disease or condition sulting in death)	a	e act line	e. I consequer	utrE	Tel	rie Jas	ast	Co	w	ni	nu		Interval Between Onset and Death
e be executed sicien and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S . O	19u	consequer consequer	e (Cor	w	no	n	Q				
eath certificate attending physi	/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,										23d Da	ate of delive	arv
it the death by the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at ti	2 ☐ Fetal de time of deat		Ectopic Other (s	oregnancy pecify)			-	-		onth	Day Year
The law requires that the death certification has been signed by the attending bage 2 should be detached for use as	þ	Part II. Other significant condition	ons contributing to	death but	t not resulti	ng in the ur	nderlying	cause give	en in Part I.		23e.	Did toba	1/		ne cause of death? ably 4 □Unknown
	Completed			_							24a.	Was an autopsy performe		Were auto prior to cor death? 1 \(\subseteq \text{Yes}	psy findings available impletion of cause of
ician: certifica rector, p	Be	25. Was case referred to medica examiner?							26. Place	of Death	(Check	only one)		
Physi this c	2	1 Yes 2 No 27. Mangfer of Death		Inpatien		VOutpatient			4 U Nuis				ce 6 □Oth		<i>(</i>)
ding I	ion	1 Natural 5 ☐ Pendir	ig (M	te of Injury onth, Day	Year)	Bb. Time of Injury	м	28c. Injury Work	/aτ ⟨? Yes 2∐N		8a. Desc	ribe now	injury occur	rred	
or Attending Physician: after docan. Director: After this certific in by the funeral director,	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Pla	ce of Injur Iding, etc.	ry - At home . (Specify)	e, farm, stre			165 2014			ion (Stre		ber or Rura	l Route Number,
To the Hospitei or Attenwibin 24 hours after deal To the Funerel Director completely filled in by the	edical Ce	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physicien: To Examiner: On the and m	he best of basis of e	examination	edge, death n and/or inv	occurre estigation	at the tim	ne, date and pinion, death	l place, ai	nd due to	the cau	ise(s) and m e and place,	anner as st	ated. the cause(s)
ro the vithin o the	Med	29b. Signature and title of certifie		4	-		2	c. License	number		-	290	d. Da e signe	ed (Month,	Day, Year)
->+·0		Loiker	u. 17	180	Inch	11		75	61	60		7	5/16	120	06
7		30. Name and address of person	who completed ca	use of dea	ath (Item 2:	3a) (Type, I	Print)	ار د		7 (~	101		YD
0 .	1	KATHERINE	IKAUT	WH	40,6	lew.	ot	MD (C 2	729	64	eei	est	,15a	Course
Sta Registr	200	31. Date filed (Month, Day, Year)	2006	Registrar	r's Signatur	Loca	de		(-	2	1201

			1- For Amend Item#3	per PHY	3836and/	1 766	appent of H	ealth a D <i>eath</i>				006	15449
Н	Physici	an	Decedent's Name (First, Middle, La	_						Date of Dear Month	th Day	Year	3 Time of Death
	/Medic	al		oone Sr.			45 Cit. T	lti		May	_13	2006	8:14 A M
	Examin	ier	4a. Facility Name (If not institution, given 3509 Alameda Cir		7		4b. City, Town, or Balt	imore			4c. C	County of Death	
	Funeral		5. Social Security Number 6. S	iex 7. A	ge (In yrs. lasi	birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birth (Month, Day,		9. Birth	place (State or Foreign
ı	Director		213-34-6242	XM 2□F	66	Yrs.	Months Days	Hours		08/16/1		Cou	Carolina
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	neation						10d. Inside City Limits
	Aanyla I shor	ъ	Maryland		. oo. o.,, ,		altimore						1√DYes 2 □ No
	28a-1	Director	10e. Street and Number				10f. Zip Code			1	0a. Citiza	en of What Cou	11
	3a or	0	3509 Alameda Cir	c1e			212	10			-	S.A.	,
	death	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Spec	cify Yes or No-	14	1. Race - Ameri	
36	d within 72 hours after death with the Maryland Jiene. Ir than "natural", or Hams 23a or 28a-1 show It e Macilcal Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give	No 1957		1 □ Yes 2√⊡ No	Specify:	, Fuelto F	iloan, etc.)	5	Black, White, Black, Bla	
21215-0036	tural	ed b	15. Decedent's Ed				dent's Usual Occupa	ation				d of Business/In	
215	within 72 ane. than "nat	Completed	(Specify only highest gra	de completed) College (1-4or		(Give life.	kind of work done of DO NOT use retired	luring most)	of workin	g		. J. 550	
	e filed within al Hygiene. othar than ' vant, Il'e M.	Com	6			Ass	embly lab	orer			Auto	mobile	
nd	0 2 0 6	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, I	Maiden S	umame)	
ryla	should by	ļ	Amnon V. Boone	Tues Defeat		405 14.15		Norma			21:		
Maryland	d 2 sl th and 17 is r traur		19a. Informant's Name/Relationship (Valerie Tamajong				ng Address (Street a Larchdal				-		
	ges 1 and 2 should t of Health and Men If Itam 27 is marka or other traumatic		20a. Method of Disposition		20b. Place		sition (Name of matory or other place					ation - City or To	
E O	Pages nent of I int: If its iry or o		ty Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		3		fatory or other place fem. Park		5/18/	2006	01+4	mara N	lary1and
Baltimore,	and and and and and and and and and and		21. Signature of Funeral Service Lick	66	mbu		2. Name and Addres	s of Facility	The	Derrick	. C.	Jones F	7/H. P.A.
<u> </u>	Dep fing gany	- 1	of the Contract of the Contrac	-		46	oll Park F	lgts.	Ave.	, Balti	more		and 21215
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plication that cause one cause on each	ed the death. I	Do not ent							Approximate Interval Between
	Physician (Madical		Immediate Cause (Final disease or condition resulting in death)	a END	STAG	6E	Myelog	eno	15	Levi	ker	nia	Onset and Death
	/Medical Examiner		1	Due to (or a	s a consequen	ce of):	Pron	~~	21/2	4.			mks
	NE TO	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequen	ce of):	Myelog Preus of	770		0			
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Oste	0000	05 15	of	Tax	U				ignos
0,	ate be executed hysician and he burial-transit	Ex	resulting in death) Last	Due to (or a	s a consequen	,							
8760,	icate b physic s the b	dlcal		o Black	due	1	20/40.	١					
9 X	death certific e attending p d for use as f	/Med	IF FEMALE:	23c. If yes, outcom	e of pregnancy	,	/				200	d Data of deliver	
Вох	atten d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth	2 Fetal de at time of death	ath 3	Ectopic pregnancy Other (specify)				23	d. Date of delive Month	Day Year
Ö.	that the c ed by the detached	hysl	9 Unknown	9□ Unknown									
S,	uires that the de signed by the a Id be detached f	by P	Part II. Other significant conditions of	ontributing to death	but not resultin	ng in the u	nderlying cause give	n in Part I.		23e. Did tob	acco use	ontribute to the	ne cause of death?
Records,	law requires as been sign 2 should be									1 🗆 Ye	s 2 🔀	No 3 ☐ Prob	pabiy 4 Dunknown
ecc	e law r has be je 2 sh	Completed								24a. Was ar autops	v	24b. Were auto	psy findings available mpletion of cause of
	Th ate pag	Con								perform 1 Yes 2	ned?	death? 1 🗌 Yes	20 No
Vital	Attanding Physician: Thr r death. actor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			t all poal Othe			(Check only on	-		
o	ding Phys h. After this funeral di	: To	1 ☐ Yes 21 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		Outpatien b. Time of	IL 3 DOA	4 Nur		e 5 Reside 3d. Describe ho			y)
ion	nding F ath. r: After e funeri	atio	1 Accident 5 ☐ Pending investigation		ay Year)	Injury		.? ′es 2□N	10				
Division	r Attand er death ractor: / by the fi	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of it	njury - At home atc. (Specify)	, farm, str	eet, factory, office		28	Bf. Location (Sti City or Town		Number or Rura	I Route Number,
	ital o	O											
	To tha Hospital or Attanuwithin 24 hours after deatl To tha Funaral Diractor:	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the bes niner: On the basis	of examination	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and inion, deatl	d place, ar h occurred	nd due to the ca d at the time, da	iuse(s) ai ate and p	nd manner as si lace, and due to	tated. the cause(s)
	To tha within 2 To tha comple	Mec	29b. Signature and title of certifier	and manner s	11		29c. License	number		29	d. Date	signed (Month,	Dav, Year)
	- 3 - 3		> (1) Ven	Keil	lyb	ny	05	47	40	9 1	1114	415	7006
1	0		30. Name and address of person who	completed cause of	de (Item 23	a) (Type,	Print)		- ·	1 /	1.1	1.0-	200
(Į.		HIEW KETLLY	801 10	01/12	250	AUE D	1,1	re	uesic	K,	MU Z	1101
	Sta Registr		31. Date filed (Month, Day, Year)' MAY 1 7 200		rar's Signature								
DHI	MH 17 Rev 1/2	-9	MAY 1 7 200	D Delen	U D.	1	W	2/32					
-11	1. 1169 1/20	-01			0.5	RIGINA	VI.						

			i icase i		Describe III. Lisute	•	
			1 _ For State	State of Maryland /	Department of Health and Certificate of Death		2006 151.50
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg.	
A. V.	Physici	ian		Brumena	1.05	Month	Day Year /
R	/Medi		GETRUBE 4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea		2 2006 6:17°M
	Examir	ner	FRANKLIN SQUARE	HUSPITAL	RuselAle	101	4c. County of Death BALTIMERE
			5. Social Security Number 6. Sex			s. 8. Date of Birth	
	Funeral Director			M 2007 89	Yrs. Months Days Hours Min	Month, Day, Ye	9. Birthplace (State or Foreign Country)
1			Usual Residence of Decedent			Tenanter 50	
	how		10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
	e Ma	cto	MD N	19	BALTIMORE		1 Yes 2 No
	or 26	Oire	10e. Street and Number	f - /	10f. Zip Code	10g.	Citizen of What Country?
	ath w	ra I	1022 EVANS		21305		U S.A.
	er de	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: white
21215-0036	within 72 hours after death with the Maryland sne. than "neturel", or items 23e or 28s-f show he Marical Examinar must be notified at	ed	15. Decedent's Educ		a. Decedent's Usual Occupation	16h	b. Kind of Business/Industry
15	n "ne	Completed	(Specify only highest grade	o completed)	(Give kind of work done during most of w life. DO NOT use retired)	orking	. Nind of Business mustry
212	filed withi Hygiene. other then ent, the M	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)	Housewi Re		Home.
	Hygie other	Φ	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	den Sumame)
<u>a</u>	Aental Aental rked o	To B	ERNEST HUHN		Helen	a Cariou	8
Maryland	2 should be and Mental is marked of sumatic eve	Γ,	19a. Informant's Name/Relationship (Type	pe, Print) 19	b. Mailing Address (Street and Number or I	Rural Route Number, Ci	ty or Town, State, Zip Code)
	1 and 2 Health a em 27 is		NANCY JU		139 RODMAN WAY	BAlto. M	0 21205.
Baltimore,	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan serinent of Health and Mental Hygiene. orfent: if Item 27 is marked other than "neture!", or items 23e or 28e-f show orfent: if Item 27 is marked other than "neture!", or items 23e or 28e-f show injury or other traumatic event, the Mudical Experiment must be notified at 8.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b. Place cemet	of Disposition (Name of ery, crematory or other place)		Location - City or Town, State
Ĕ	Pages ment of the ent: if its ury or o		4 Donation 5 Other (Specify)		iew CremaTory		BALto.MJ.
alt	permit. Pag Depertment Importent: I eny Injury c		21. Signature of Funeral Service License	98	22. Name and Address of Facility PAUL STELLA FUN 7527 has ford RD	exal Home .	PA
<u> </u>	Dep imp		Jane 911.	J Lella	7527 has ford RA	BAlto M.	0 21234
			23a. Parf1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do	not enter the mode of dying, such as cardi		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Bowe	/		Onset and Death
Ş.	/Medical		resulting in death)	Due to (or as a consequence	1		
	Examiner		Sequentially list conditions.	Sees	Sis		
11/	면 #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events	Due to (or as a lonseq in ce	a of);		
K	ecute and -trans	Examin	that initiated events resulting in death) Last				
760,	te be executed ysician and te burial-transit	E	in John Jan Salari, Laur	Due to (or as a consequence	3 or):		
	# × B	dical					
9 X	The law requires that the death certificat lie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy			
Вох	atten for u	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
P.O.	t the de by the a tached t	ysic	1 Yes 2 No	9☐ Unknown	5 Unter (specify)		
مز	that 19d by deta		Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
Records,	uires I sign Id be	d by				1 🗆 Yes	2 No 3 Probably 4 Unknown
00	w require been si should b	Completed				24a. Was an	24b. Were autopsy findings available
Re	The lav	E G				autopsy performed	prior to completion of cause of
		ပို	25. Was case referred to medical			1□ Yes 2Ū	
Ē	Physicien: this certific ral director.	To B	examiner?	ospital:	Othor	eath (Check only one)	2 [] () ()
ō	ding Phy h. After the tuneral c		27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	Home 5 Residence	
ion	nding r: Aft e fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Work? M 1 Yes 2 No		
Division	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home,	arm, street, factory, office	28f. Location (Street	t and Number or Rural Route Number,
	s afte s afte of in	Certification:	4 Li Homedo	building, etc. (Specify)		City or Town, St	ate)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledg	ge, death occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
	he H in 24 he F plete	edical	one)	and manner stated.	nd/or investigation, in my opinion, death occ	curred at the time, date	and place, and due to the cause(s)
	To the twithin 2 To the Complet	Σ	29b. Signature and tyle of certifier	. ^	29c. License number	29d.	Date signed (Month, Day, Year)
•			Moller	(M)	1)0063	16 (5	5/12/2006
	7		30. Name and address of person who co		(Type, Print)	0 1	2 464
	ノ		Dr Mohamed	1455IN, 9000	OCTYPE. Print) Franklin Stoare Dr	Balto.Mo	71737
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	And i		
*	Registr	ar	MAY 1 7 200	Belles S.	Start Start		

DHMH 17 Rev 1/2001

MAY 11, 2006

ROBERT BEAN

			1 - For State Registrar	State of	Maryland / Dep	partment of Fertificate of			giene , Reg. No. ^C	2006	15452
	Physici	an	1. Decedent's Name (First, Middl	e, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		CHARLES	THOMAS		INGHAM		05	09	2006	1538 "
ž	Examir	er	4a. Facility Name (If not institution		1	4b. City, Town, or	r Location of Deat	th	. /-	ounty of Death	
				ice at the		Salis	bury	-		comico	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda Yrs.	Months Days	Hours Min.	. (Month, Da	y, Year)		lace (State or Foreign
	Director		218-16-5412 Usual Residence of Decedent		79 113.			July 5,	1926	Mary	land
	land land		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	Mary	ğ	M			Q:	-C!-13				1 ☐ Yes 2 💢 No
	1 the	Je C	Mary Land Sc 10e. Street and Number	omerset		10f. Zip Code	sfield		10g. Citize	on of What Coun	itry?
	38 o	0	4183 Lawson Bar	mag Road		2.	1817			II	SA
	deat	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S.	. Was Decedent of H If Yes, specify Cuba		Specify Yes or No	- 14	I. Race - Americ	an Indian,
9	or ite		1 Never Married 2 Marr		□No World	_		to Hican, etc.)		Black, White,	
පූ	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow ta Medical Exemiter mat be neithed at	Completed by	3 ¼ Widowed 4 ☐ Divorced	Year or Date	s:War II	1 ☐ Yes 2 ☒ No	Specify:		5	ipecify:	White
5	72 h	ete	15. Deceden (Specify only higher	t's Education st grade completed)	(Gi	edent's Usual Occup	durina most of wo	rking	16b. Kind	of Business/Inc	dustry
2	han han	g E	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use retired		-			
2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle,	(act)		Machin		me (First, Middle,		leum Pr	oducts
au	d be f	Be		,					маюеп з	umame)	
Ž	should be and Mental marked of umatic ev	ဥ	John Brittingha 19a. Informant's Name/Relations		10h Ma	ling Address (Street	Daphne :				O. 7-1
Maryland 21215-0036	C1 00 = 00				Va. 1 199.V				, , ,		,
	1 and Health om 27		Charles T. Brit	tin gham,	20b. Place of Dis	4179 Lawso		s Road - Date		IIELG, ation - City or To	
ē	Pages nent of ant: if its		1 Burial 2 ☐ Cremation		ate cemetery, ci	ematory or other plac	1				
Baltimore,	permit. Pages 1 ar Department of Hea Important: if Item any injury or othe once.	1	4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	The state of the s		's Cemeter		2/2006	Maric	n Stati	on, Marylan
Ba	permit. Departm Importal any inju		Maurett	KILLEKSKAW	Luit	Bradshaw	& Sons				
			Mary Beth . 23a. Part1. Enter the disease, or	radshaw-Pr	sed the death. Do not e	306 W. Ma	g in St.	– Crisfi	eld,	Marylan	d 21817 Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	h line.	11	_		.,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. //RTG	as a consequence of):	ustate	Cane	en			
	Examiner			Due to (or	as a consequence or.						
		jer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of):					1.1.1.1	
H	d d ansit	Examiner	Cause (Disease or injury that initiated events	c							
o,	an ar		resulting in death) Last		as a consequence of):						
8760,	The law requires that the death certificate be executed to the law requires that the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		d			1700				
39	ng pt	Med	IF FEMALE:						1		
Вох	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outco		□Ectopic pregnancy			23	d. Date of delive	,
Н	ed fo	Sici	in the past 12 months? 1 Yes 2 No	4☐ Pregnar 9☐ Unknow	t at time of death / 5	Other (specify)				Month	Day Year
о. О	w requires that the death certific been signed by the attending p should be detached for use as	P.	9 Unknown								
ń	igner igner be d	٥	Part II. Other significant condition	ons contributing to deal	h but not resulting in the	underlying cause give	en in Part I.		V	•	e cause of death?
5	een s	ted		·				101	(es 2)	No 3 Proba	ably 4 Unknown
ec	law las b	nple						24a. Was		24b. Were autop	osy findings available inpletion of cause of
Œ =	The page	Completed						perfo 1 ☐ Yes	2X No	death?	2 □ No
ita 	Attending Physician: r death. ector: After this certifici by the funeral director.	Be	25. Was case referred to medical examiner?					ath (Check only o	ne)		
5	hysi this o	မ	1 ☐ Yes No		atient 2 ER/Outpatie		4 Nursing r	lome 5 Resid	dence 6 (Other (Specify)
Ĕ	ing F	on	27. Manner of Death 1 Natural 5 Pendin	9	njury 28b. Time Day Year) Injury	Work		28d. Describe h	now injury o	occurred	
<u>s</u>	ttendi death. ctor: A y the fu	cat	2 Accident investion 3 Suicide 6 Could in	as be			Yes 2 No				
Division of Vital Records,	after of Direction by	Certification:	4 Homicide determ	ined 288. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and i vn, State)	Number or Rurai	Route Number,
ш	pital purs a srai [200 Continu	- Obviolation To the b							
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier Certifyin (Check only one) Certifyin	g Physician: To the be Examiner: On the basi and manner	est of my knowledge, deas s of examination and/or i	ith occurred at the time investigation, in my op	ie, date and place pinion, death occu	e, and due to the our arred at the time, o	cause(s) ar date and p	nd manner as sta lace, and due to	ated. the cause(s)
	To the H within 24 To the F complete	Me	29b. Signature and title of cortifle	1)	29c. License	number		29d. Date	signed (Month, L	Day Year)
)	- 3 F 8	4	Jul Co	14	MM)	N o	1/27	5	<	10-1	2/
•	./		30. Name and address of person	ado completed	of death (Item 22=) (Time	Print)	100/	0		10-0	6
	5		Name and address of person) Pro III	herein (110H 23a) (Type	D 7 (A) (Print) (B) x 173	2 0	n 1012	ns	216	77
3	Sta	te	31. Date filed (Month, Day, Year)	32 Reg	istrar's Signature	W/ /15	0	* Ita		010	
100	Registr		MAY 1 7 2	200	W An	100					

DHMH 17 Rev 1/2001

			For State	State of M		epartment of Certificate of		nd Mental Hy	giene Reg. No.2006	15453
*	¥		Registrar 1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	3. Time of Death
15	Physici	_	Charles Edward E	rittain.	TV			Month	7 2006 Year	1410 M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of	Death	4c. County of Dea	th
			Prince George	3	1	Cheve	14		Prince	beoxis
	, Funeral		5. Social Security Number 6. S	9x 7.Ag S⊋M 2□F	ge (In yrs. last birtho	Months Days		Min. (Month, Da	th ly, Year) 9. Bir C	thplace (State or Foreign ountry)
1	Director		218-84-9272 Usual Residence of Decedent	X 2	30 Yrs	5.		Dec. 11	,1975	MD
	land wc		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Mary	ō	PA Adams		Litt	lestown				1 ☐ Yes 2X No
	128a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	3a o	Q i	23 South Queen S	treet. Ap	t. 3		17340		USA	
	deatl	Funerai Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of	Hispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)		
9	or Ite	F.	1 X Never Married 2 ☐ Marned	1 □ Yes 2 ☑ If Yes, Give	No	1 ☐ Yes 2 🛱 No		, , , , , , , , , , , , , , , , , , , ,	Specify:	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f show the Madical Exeminer must be natilied at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 10 5				WI	nite
<u>7</u>	"nati	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(0	ecedent's Usual Occi Give kind of work don fe. DO NOT use retir	e during most	of working	16b. Kind of Business	vindustry
12	withir ane. then	g m	Elementary/Secondary (0-12)	College (1-4or	5+)	reman	/		Construct	tion
	e filed at Hygie other vent, it		17. Father's Name (First, Middle, Last)			I Ciliati	18. Mother	's Name (First, Middle		21011
lan	ld be ental ked c	To Be	Charles E. Britt	ain III			Lind	a Lee Bill	ings1v	
Maryland	shoul nd M	1-	19a. Informant's Name/Relationship (19b. N	lailing Address (Stree			er, City or Town, State,	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be natilised at		Charles E. Britta	in, III F	ather 217	Homevale	Road.	Reistersto	wn. MD 2113	36
re,	ten of Heal		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pl	ace)	Date	20c. Location - City of	Town, State
E	Page: nent o int: If		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			wn Cemeter		5/16/06	Baltimore	e, MD
Baltimore,	permit. Pages Department of t Important: If Its any injury or of		21. Signature of Funeral Service Licer	ISBB 0 0		22. Name and Add	ress of Facility	118	24 Reisters	stown Road
m	89 5 8		1247	/_		Eline Fur	neral H	ome Rei	sterstown,	MD 21136
表			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each l	d the death. Do no ine.	enter the mode of dy	ring, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. clos	ed He	ad In	ury			Criset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of)	_	1			
2	Examiner		Sequentially list conditions, if any, leading to immediate	b						
	pe sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)					
	and I-tran	Examine	that initiated events resulting in death) Last	cDue to (or as	a consequence of)					
8760,	cate be executed obysician and the burial-transit									
687	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medicai	12.50	d						
Box (leath certifics attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	alivery
ă	atter 1 for u	ciar	in the past 12 months?	1 □Live birth 4 □Pregnant a	2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Month	Day Year
P.O.	that the di ed by the detached	hys	9 Unknown	9□ Unknown						
	requires that the leen signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to death t	but not resulting in t	ne underlying cause g	jiven in Part I.	23e. Did t	tobacco use contribute t	to the cause of death?
Vital Records,	v require been sig should b							1	Yes 2⊒No 3□P	robably 4 Unknown
ပ္တ	> 40	piet						24a. Was		utopsy findings available completion of cause of
Ä	0 5 0	Completed						perfo	rmed? death?	s 2 No
ita	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place	of Death (Check only of	one)	
of V	tending Physician: leath. tor: After this certifici the funeral director,	To	1- Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Outp	atient 3 DOA	ther: 4 Nurs	sing Home 5 ☐ Resi	dence 6 Other (Spe	ecify)
0	Jing P		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Tin ay Year) 1nji	ıry W	ork?	0.0	how injury occurred	Fell from
sio	Attending it death.	cati	2 Accident investigation 3 Suicide 6 Could not b	7057		3	Tes 2□N			
Division		Certification:	4 Homicide determined	building, e	itc. (Specify)	, street, factory, office	9	City or To	Street and Number or Fi wn, State) 5/23	suit/and
	Hospital 24 hours a Funeral I tely filled	ပိ	29a. Certifier 1 ☐ Certifying Ph	Apart		all ding	time date and	Read,	cause(s) and manner a	MANG/AND
	To the Hospital or Ai within 24 hours after of To the Funeral Direction Direction by	edicai			of examination and/				date and place, and du	
8	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mon	th, Day, Year)
	F 3 F 8		120.1	Mesto	20	Ho	0558	27	Mar 10 -	2006
	7		30. Name and address of person who	completed cause of	death (Item 23a) (To		-0-	, ,	7 7	
			Salvador Sylvet	5 3001	HOSDI TO	of Drin	e, cho	very M.	Any land	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature	1 4	,)	
	Regist	ar	MAY 1 7 2	DOS BOOK	w J.	Geste				

State of Maryland / Department of Health and Mental Hygiene 🤈 15454 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Helen D Bright

4a. Facility Name (If not institution, give street and number) 05 8:43 /Medical 2006 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 110 N. CENTRAL AVENUE BALTIMORE NA Months Days Hours Min. SEPT I, 1933 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🛱 F 218-28-6272 72 MARYT AND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iteme 23a or 110 N. CENTRAL AVENUE 21202 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ADivorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) HOMEMAKER DOMESTIC permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MILTON BROWN ELSIE BROWN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANTE JACKSON SON 560 SERINITY CT, APT. G ODENION, MARYLAND 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK CEM MAY 18, 2006 RANDALLSTOWN, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityWYLIE FUNERAL HOME P.A. 21. Signature of Funeral Service Licenses 638 N. GILMOR STREET BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHENOSCIENOTIC CANDIOVASCULAR unknown /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy N/A 23b. Was decedent pregpant 23d. Date of delivery N/A 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DIABERS MELLINGS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown Completed NEWAL FAILUNE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CHNONIC autopsy performed? HYPENCHOUS PENOUMIA 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1∭Yes 2 No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To his 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? N/A 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 14 Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after within 24 hours a To the Funeral D 1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51571 05/16/06 M.D. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANBANA L. SANICO M.D. GBMC WEINBERG CENTEN, 1200 E. FAYETTE ST., BALTIMONE, MD 52: Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of Ma	aryland		rtmen tificate			ind M		Reg. No.	200	6 15	455
Physic /Med Exami	ical	4a. Facility Name (If not institution, give	e street and number)					Location o		2. Date of De Month	Day 1 1 4c.	Yea 4 200 County of D	% 7 ∶ 2 eath	Death
Funeral Director		NORTHWEST HOSPIT 5. Social Security Number 186-12-2595 Usual Residence of Decedent		e (In yrs. Ia:	st birthday) Yrs.	If Under Months		STOWN If Under 2 Hours		8. Date of Bi	rth	9.1	Birthplace (State	or Foreign PA
the Maryland 28a-f ehow	rector	10a. State 10b. County MD N/	Ά	10c. City,	Town or Lo		Code				10a Citi	izen of What		ity Limits 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, the Modical Examinar must be notified at once.	by Funeral Director	100 HARBORVIEW D 11. Maritaf Status 1 Dever Married 2 Married 3 M Widowed 4 Divorced	12. Was Decedent Armed Forces? 1	Ever in U.S.	1		ent of His	2123 spanic Orig n, Mexican, Specify:		cify Yes or No Rican, etc.)			USA merican Indian,	E
ed within 72 hour ygiene.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-32)	ducation ide completed) College (1-4or 5	+)	16a. Deced (Give life. L HOMEM	kind of wor OO NOT us	k done d	luring most			OWN	nd of Busine	ss/Industry	
hould be fill d Mental H marked off	To Be	17. Father's Name (First, Middle, Last) WILLIAM 19a. Informant's Name/Relationship (BLUES		(Straat a	HILI	DA	(First, Middle I Route Numb			CHARKATZ	
is 1 and 2 s of Health an item 27 ier		EILEEN COHEN / D	AUGHTER	20b. Pla		ARBOR	RVIEV	V DRIV	VE #3		BALT	IMORE	or Town, State	30
permit. Page Department of Important: If eny injury or once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specification of Specification of Specification) 1 Service (Specification) 1 Se	11		OM ME		AL PA	ARK (RELAND,	PA
cate be executed /Medical Examiner and the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ather Due to (or as: b. Due to (or as: Due to (or as: Due to (or as: d.	os U a conseque a conseque	erot ince of): lig. nce of):	ic C	of dying	nar C	Ar	tery a	Dis	ease	Approximat Interval Bet Onset and I	e ween Death
w requires thet the death certific we require the the death certific been signed by the attending p should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregpant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe					2	23d. Date of o	,	Year
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Completed by Ph	Part II. Other significant conditions o	ontributing to death bu	ut not result	ing in the ur	derlying ca	iuse give	n in Part I.		1 🗆	Yes 2[No 3□	Probably 4 24 autopsy findings o completion of completion	nknown
	o Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital: 1 ☐ fnpatie		R/Outpatient		Othe	~		1 ☐ Yes (Check only o	rmed? 2 No one)	death 1 🗆 Y	? es 2□ No	ause of
To the Hoepital or Attending Physicien: Within 24 hours elter death. To the Funeral Director: Atter this certific:	ertification: T	2. Manner of Death 1. Property of Death 2. Accident 3. Suicide 4. Homicide Germined	28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	M 28	Sc. Injury Work 1 Y	4 🔲 Nur	10	8d. Describe 8f. Location (City or Total	how infun	y occurred d Number or	Rural Route Num	ber,
To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Examone) 29b. Signature and title of certifier	ysician: To the best of tiner: On the basis of and manner sta	examinatio ted.	n and/or inv	estigation,	License	number	n occurre	d at the time,	29d. Date	place, and d	as stated. ue to the cause(s nth, Day, Year)	
St	ate	30. Name and address of person who of 540 L C C C C C C C C C C C C C C C C C C		a. R	anda.			00564 , M		2113	mai 3	14	200	6

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		-	For State Registrar	State of M	laryland		artmen rtificate			and M	lental H	ygier Rag. N	2001	6 15456
			Decedent's Name (First, Middle,	Last)							2. Date of D	eath		3. Time of Death
	Physici		REBEC	CA	S.		BL	ACKE	R		May	15, ^ˈ	2006 Ye	7:20A M
	/Medic Examin		4a. Facility Name (If not institution,)		4b. City,	Town, or	Location o	of Death		4	c. County of E	
			Civista Medica	al Center			La	Plat	a				Charle	es
14	Funeral			6. Sex 7. A	ge (In yrs. la	ast birthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of B	irth	9.	Birthplace (State or Foreign
>	Director		216-03-3306	1□M 2\F	86	Yrs.	Widning	Days	110010		08708	191	9	MD MD
	pu 🛊 🗆		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside City Limits
	ith the Marylar or 28a-f ehow	2		TIMORE		BALTII								1 ☐ Yes 2 🌠 No
	Ne M	ecto	MD BAL	TIMORE		DALIII	10 KL	Codo				100.0	Citizen of Wha	
	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f ehow lical Examiner must be mulified at	by Funeral Director	1450 BEDFORD A	VENUE #714			101. Zip		21208	1		log.	J. 1. 2011 01 11114	USA
	eath w	era	11. Marital Status	12. Was Deceden	t Ever in U.S	5. 13.1	Was Deced				ecify Yes or N	10-	14. Race - A	American Indian
	Item Item	'n	1 Never Married 2 Marrie	Armed Forces	?		f Yes, spec	ify Cuba	n, Mexican	, Puerto	ecify Yes or N Rican, etc.)		Black, V	Vhite, etc.
36	Irs af	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes 💈	2 X №	Specify:				Specify:	WHITE
5-0036	2 hou	ted	15. Decedent's	s Education		16a. Dece	dent's Usua	Occupa	ation	e mé comme		16b.	Kind of Busine	ess/industry
215	hin 7	pie	(Specify only highest	College (1-4or	5+)	life.	kind of wor	e retired,)	OF WORK	ng			
2121	giene giene	Completed	Elementary/Secondary (0-12)			SALE	SPERS	ON				RI	ETAIL	
	al Hy al Hy oth	Be (17. Father's Name (First, Middle, L.	ast)							First, Midd	le, Maide		ACVEDILITY
Maryland	s 1 and 2 should be filed within 72 hours after dea I Health and Mental Hygiene. Item 27 ie marked other then "naturel", or Iteme other traumatic event, the Medical Examination	2	HARRY			SEIDE	_		SADI	Ł.				1EYERWITZ
an	and and in ma		19a. Informant's Name/Relationsh				3	*					or Town, Sta	te, Zip Code)
	s 1 and 3 Health Item 27 other tr		HARRY J. BLACK	ER / SUN					UKI -		DORF,	,		
ore	ges 1 if of He or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □ Bemoval from State	Ce	ace of Dispo metery, crea	natory or of	ther place			Date	20c.		or Town, State
Ĕ	Pag ment ant: ury c		4 □Donation 5 □ Other (Sp	ecify)	MOSE						72006			HORPE, MD
Baltimore,	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service L	icensee										S., INC. E, MD 21208
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	d the death.	. Do not ent	er the mode	e of dying	g, such as	cardiac (or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Tect	line. Le Mu s a conseque H R	ir b	morel		hice.	ase	•			Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequ	ence of):	-						·	
	Examiner		Constitution and distance	, Aw	HR	eno	P Ja	ilu	re					
2.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	ence of):								
	cutec nd ransi	Examiner	that initiated events	. Acut	e m	I								
0	an ar	EX	resulting in death) Last	Due to (or as	s a consequ	ence of):								
8760,	ate be executed hysician and the burial-transit	dical		d										
9	eath certifica attending ph I for use as t	Med	IF FEMALE:											
Вох	ith ce tendi	by Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	e of pregnan 2 Fetal	death 3	Ectopic pr						23d. Date of Month	delivery Day Year
	e death he atten	sici	in the past 12-months?	4□Pregnant a 9□Unknown	at time of de	ath 5	Other (sp	ecify)					MONIT	Day
P.0	at the	Phy	9 Unknown						1.0.1		ana Dia	Linkana		to to the course of death?
	w requires that the death been signed by the atte should be detached for	þ	Part II. Other significant condition	is contributing to death	but not resul	iting in the u	nderlying ca	ause give	n in Paπ I.					te to the cause of death? Probably 4 Whitnown
ord	equii sen s	ted									1] Yes	2 L NO 3 L	Floodbly 4 Addikilowii
Division of Vital Records,	as b	Completed										opsy	prior	e autopsy findings available to completion of cause of
<u> </u>	: The law cate has I , page 2 s	Son									per 1 Yes	formed2 2 X N	deat	h? Yes 2□No
/ita	Physician: The this certificate rat director, pag	Be (25. Was case referred to medical examiner?						26. Place	of Deatl	(Check only	one)		
Ž	hysic his co	2	1 ☐ Yes 2X No	Hospital: 1 Inpat		ER/Outpatier			4 1140				6 □Other (Specify)
ם	nding Physath. rr: After this refunerat dir	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how in	jury occurred	
Sio	eath. or: A	cati	2 Accident investiga	ation			М	1 🗆 \	res 2⊡t					
Ξ̈́	or Att	E I	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of Ir	njury - At hor etc. <i>(Specify)</i>	me, farm, str)	eet, factory	, office			28f. Location City or T	(Street own, Sta	and Number o ite)	r Rural Route Number.
	itel or raf	Ce												
	Hospitel	edicai	(Check only 2 Medical E	Physician: To the bes xeminer: On the basis	of examinati									
	the opto	Med	29b. Signature and title of certifier	and manner s	siated.		290	. License	number			29d F	ate signed (M	fonth, Day, Year)
	or with	_	255. Signature and the of continer				en			0			15/2	
^			11/				MD	ח–ח	05321	9		7/	1710	
3	1		Name and address of person w	•				,	_					
			Zafar A. Ansari 31. Date filed (Month, Day, Year)	32 Regis	OST OF trar's Signati	Ilce I	koad l	wald	orf,	Mary	⊥and 2	0602)	
	Sta Registi		MAY 1 7 2	2006	J M.	Ann	while of							

_			1- State of Maryland / Department	rtment of Health and M tificate of Death		ene2008	15458
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	_	3. Time of Death
	/Media	cal	Frank Joseph Braun 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May	8 2006	
1	Examir	ier	Mariner Health of North Arundel	Glen Burnie			Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
Ų	Director		215–36–8197	Noners Days Flours Will.	June 14		ryland
	/land		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
	a-f e-f	ctor	Maryland Anne Arundel Linthicu	m			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	10f. Zip Code	1	g. Citizen of What C	,
	eath v		1117 Furnace Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21090		United Sta	
Maryland 21215-0036	172 hours after death with the Maryland "neturel", or fleme 23e or 28e-f ehow digel Examinational be notified at	by Funeral	Armed Forces? If 1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto Yes 22 No Specify:	Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0	72 ho	Completed	(Specify only highest grade completed) (Give I	ent's Usual Occupation kind of work done during most of worki	na 16	6b. Kind of Business	/Industry
121	within ene. then	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)		_	
d 2	0 0 =	e Co	12 Con 17. Father's Name (First, Middle, Last)	Itractor			Construction
/lan	ould be Mental arked c	To B	Frank Benjamin Braun	Mildred 1	Minnie Ir	mbragulio	
lary	S D E E		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Address (Street and Number or Rura	l Route Number, (City or Town, State,	Zip Code)
	s 1 and 2 of Health a ttem 27 is other train		Rosie Bertha Braun / Sister 4611 20a. Method of Disposition 20b. Place of Disposition	Kramme Avenue, Ba	-		
	Pages nert of I int: If ite		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crem	1		oc. Location - City or	
altir	교육원급 .		Them eating			altimore, neral Home	
ä	Depa Impo eny ii			107 Wilkens Avenue			•
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	r the mode of dying, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
П	Examiner		Due to (or as a consequence of):				
	cuted od ansit	Examiner	Sequentially list conditions, if any, leading to infrindiate cause. Enter Underlying Cause (Disease or injury that initiated events to the conditions of the				
8760,	icate be executed physicien and s the burial-transit		resulting in death) Last Due to (or as a consequence of): d.				
x 68	ertifica ling ph	Med	IF FEMALE:				
P.O. Box	The law requires that the death certificate be executed ase hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical		Ectopic pregnancy Other (s <i>pecify</i>)		23d. Date of del Month	ivery Day Year
ď.	s that gned b		Part II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ord	w require been signature should b	ted	Septe arthreto, Perphyal V	as when defeate	1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Dunknown
Division of Vital Records,	sicien: The law i certificete hes bi rector, page 2 sh	Completed by			24a. Was an autopsy performe	d? prior to death?	ntopsy findings available completion of cause of
Ĭ.	sicien certifi rector) Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
o	Attending Physicien: or death. ector: After this certifice by the funeral director.	n: 70	27. Manner of Death 28a. Date of Injury 28b. Time of	3LI DOA 4 PINUISING HOM	ne 5 Residence 8d. Describe how	e 6 □Other (Specinjury occurred	cify)
ion	death. ctor: Aft y the fun	atlo	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Divis	tal or Attend is after death al Director: ed in by the f	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge death 2 Medical Examiner: On the basis of examination and/or invegand manner stated.	estigation, in my opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	T vit	Σ	29b. Signature and title of certifier	29c. License number	1	. Date signed (Monti	
•	1	1	20 Name and address of assets	158458	15	18/06	
3+	17		30. Name and address of person who completed cause of death (Item 23a) (Type, P	D38458 in Hylway Sw	Clar R.	mes Ma	121061
1 5.	Sta Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature	the state of the s	VUN VI	111111 1 * ()	12100/

06-03011 Harold Collins

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of Death	7.5	Reg. No.	
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	eath Year	3. Time of Death
January .		Harold Michael Collins 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	May 3, 2	4c. County of De	1130 hrs
		Johns Hopkins Hospital Baltimore			
Funeral Director		Months Days Hou	der 24Hrs. 8. Date of E	9. I 1961 For	Birthplace (State or eign
		220-78-1993 1XM 2F 45 Yrs. Months Days Hou	April	27, 200	Country) Maryland
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
riand -f shov	tor	Maryland Baltimore			1 Yes 2 No
e Marr or 28a	Director	10e Street and Number 10f. Zip Code 2121	4	10g. Citizen of What Co	puntry?
rath with the Maryland items 23a or 28a-f show any st he notified at once,		505 South Umbra Street 21214 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or		U.S.A.	erican Indian, Black,
death	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.	shoar malan, black,
rs after ural",	þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give		Specify: Whi	
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	Rind of work done Tuse retired)	16b. Kind of Busines	s/Industry
0036 within iene er than	dmo	6 Disabled		Disable	ed
21215-0036 ould be filed within 72 Mental Hygiene marked other than event, the Medical	Be Co		er's Name (First, Middle,	· ·	
212 ould be d Ment s mark ic ever	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	mio Ruth W	alls Imber, City or Town, Sta	te, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Samantha R. Collins/Sister 3810Sunnyfield Cou	ırt#3C Hamp		
Ore, ges lan of Her ther tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State
Itim it Pag irtment ortant: y or o		4 Donation 5 Other Specify: Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	5/8/2006	Baltimore	
Balt permit Departi Import injury		Buchael P. Barxullor 6009 Harford Ro	Marzullo I	Funeral Cha	pel,P.A.
Physician		23a. Part I. Enter the disease, 'r complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.	cardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Acute intraventricular hemorrhage of the	brain with co	omplications	Death Death
and the second		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
sd Sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			1
executed in and il - transit	g	X AMENDED item#8,23a,27,perFH,ME,g857,7/5,	706 111		
760, ficate be executed g physician and the burial - transi	/Medical	IF FEMALE: 23c If yes, outcome of pregnancy		23d. Date of delive	
OX 687 sath certific attending p	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopi	c pregnancy	Month Month	Day Year
Box 68 death certif the attending of for use as	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)			
	by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P		obacco use contribute to	
ls, P.C quires that en signed l	ted t			s 2 No 3 Pro	
cords, law requir has been s	Completed		24a. Was	osy prior to	utopsy findings available completion of cause of
tal Rec		25. Was case referred to medical 26 Place of Death	1 🗸 Yes		es 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death 11 Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach	o Be	examiner?	(Check only one) Nursing Home 5	Residence 6 Other	or.
1 of Jing Ph	ايّا	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work		how injury occurred	
Sior Attend r death ector: by the	ertification:	2 Accident Investigation 1 Yes 2			
Divisic Hospital or Atte 24 hours after dea Funeral Director tely filled in by th	ertifi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, et (Specify)	tc 28f. Location (or Town, S	Street and Number or Ri State)	ural Route Number, City
Hosp 24 hou Function	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the caus	se(s) and manner as sta	ted
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated	curred at the time, date	and place, and due to the	ne cause(s)
_	2	29b Signature and title of certifier 29c License number O.C.M.F.		29d. Date signed (Mo	nth, Day, Year)
	-	O.C.M.E. O.C.M.E.		May 6, 2006	
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist		MAY 1 7 2008 Been St. April			

			Fiease	State of Marylan				•	_	
			For Stata Registrar	State of Marylar		rtificate of L			/	15460
	25 25		Registrar 1. Decedent's Name (First, Middle, La	iet)	00	unicate of L	Jeani	2. Date of Deat	eg. Nó	3. Time of Death
	Physicia	an	1. Decements Name (Pilst, Middle, La		N	LEMAN	1	Month	Day Yea	
	/Medic	al	DOKA	o street and symbos)	00	4b. City, Town, or	Location of Dea	MAY	4c. County of De	10,0x1.
	Examin	er	4a. Facility Name (If not institution, given	0.0		B		YORE		J/A
	327	223	5. Social Security Number 6.5	Sex 7. Age (In yrs.	. (last birthdav)	If Under 1 Year	If Under 24 Hr		/	irthplace (State or Foreign
	Funeral Director			1□M 2 X F	2 Yrs.	Months Days	Hours Mir		7 (923 N	ORTH CAROLINA
80	40		Usual Residence of Decedent				L	114012	7112	KINCHROLINA
	ehow		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow must be motified at	tor	MARYLAND	VIA	•	DAL	TIMOR	RE CIT	-1/	1 Yes 2 □ No
	th with the M 23a or 28a-f	Funeral Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What	Country?
	h wit	al D	20 CATALA	A COURT			2120	9	USA	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	ispanic Origin? ((Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian,
0	after or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2 🗷 No If Yes, Give		1 ☐ Yes 2 🗷 No	Specify:	The state of the s	Specify:	nto, oto.
0000	rai,	d b	3 X Widowed 4 □ Divorced	Year or Dates:	95	12.00 22.00	ороску.		B	LACK
ה	be filed within 72 hours after death with the Maryla ital Hygiens than "natural", or iteme 23a or 28a-1 ehov event. The Medical Examinar must be motified at	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa kind of work done	during most of w	orking	16b. Kind of Busines	ss/Industry
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V	filed with Hygiene other tha	S	12+HGRADE	4)	NURS	ING HOP	18 Matheria N	ENDANT		YG HOME
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ROX	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>	,		Month	Day Year
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J.	The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as th	4 7	Part II. Other significant conditions	Contributing to death but not re:	sulting in the u	inderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
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	Physician: The law this certificate has b al director, page 2 s	o Be	examiner?	Hospital: 1 Inpatient 2] ER/Outpatie	ot 30 DOA Oth	05	eath (Check only on	ence 6 Other (S	Dogify)
Division of	ng Phys ter this neral di	 	27. Manner of Death	28a. Date of Injury	28b. Time o				ow injury occurred	Jeony)
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	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai	(Check only 2 Medical Exa	iminer: On the basis of examinand manner stated.	ation and/or ir	ivestigation, in my o	pinion, death oc	curred at the time, d	ate and place, and d	ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0 1/2	×	29c. Licens	e number	7	9d. Date signed (Mo	
	d.		Allex	sel this		DZ	28870	/	vide, 1	5,2006
	in		30. Name and address of person who	completed cause of death (Ite	т 23а) (Туре	Print) 72/			Q 11	5,2006 WDR MD
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Description of the control of the co	of Birth 9. Birthplace (State or Foreign Country)
10 10 10 10 10 10 10 10	29, 2006 Maryland
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College (1-4of 5+) College	1 ☐ Yes 2X No
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College (1-4of 5+) College	s or No- stc.) 14. Race - American Indian, Black, White, etc.
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Comparison Com	25438
Physician (Medical Examiner) 23a Part Finer the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on sect hine. Immediate Cause (Final Precisions) Sequentially iss controlled. Sequentially issociated and issue of the case of injury results to the case of injury and in the past 12 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 yes 20 months? 10 ye	20c. Location - City or Town, State
Physician //lodical Examiner Physician //lodical Examiner	55 W. Baltimore Street
Sequentially ist conditions, if any, leading to immediate current and in the past 12 months? Comparison of the past 12 months? Compar	atory arrest, Approximate Interval Between Onset and Death
FEMALE: 23b. Was deededn pregnant in the past 12 months? 1 1 2 1 2 2 2 2 3 3 2 2 2 3 3	
25. Was case referred to medical examiner? 1	23d. Date of delivery Month Day Year
25. Was case referred to medical examiner? 1	e. Did tobacco use contribute to the cause of death? 1 Yes 2 170 3 Probably 4 Unknown
25. Was case referred to medical examiner? 1	autopsy performed? prior to completion of cause of death?
27. Manner of Death Matural Matural Month, Day Year) 28b. Time of Injury 28b. Time of Injury at Work? 1 Matural 2 Accident 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location (Street and Number or Rural City or Town, State) 28f. Location	only one)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This is a Mah (200 M. Wolfe, St. DAH; More MAKY And 200)	to the cause(s) and manner as stated. • time, date and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This is a Mah (200 M. Wolfe, St. DAH; More MAKY And 200)	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This is a Mach 1000 W. Wolfe St. Makington Maky Idan 1276	MAN 6 700C
State 31. Date filed (Month, Day, Year) 3#. Registrar's Signature	MALY 1911 21287
State 31. Date filed (Month, Day, Year) 37. Registrar's Signature Registrar MAY 1 7 2006	1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20a-c,22 perFH_0855.5/22/06 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 8:54 Fm Ruby Clayland

4a. Facility Name (If not institution, give street and number) May 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Mar 5, 192 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. unk 84 Director 213-16-5198 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygione.
ant: If them 27 is marked other than "natural; or tieme 23a or 28a-f show ury or other traumatic event, tra Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the reduction of the Medical Easts or the Medical East or the Medical Ea 1X Yes 2 □ No Directo Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 501 W. Franklin Street 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Black, White, etc. unk 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk unk ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Medical Center 22 S. Greene St. Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Buria.
4 □ Donation 5 Hother (2)
21. Signature of John Park Service Licensee
Ronald S. Wada, 1 M Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If eny injury or once. 4 □Donation 5 Other (Specify) in state Trinity Cemetery 5/20/2006 Baltimore, MD 22. Name and Address of Facility Phillip A. Weatherford F.S. 2431 E. Oliver State Anatomy Board 655 W. Baltimore Street St. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septicemia resulting in death) /Medical Due to (or as a consequence of): Examiner Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) signed by the eld be detached for ☐Yes 2 No P.0 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Aortic Angurysn 24b. Were autopsy findings available prior to completion of cause of death? Gastro intestinal autopsy certificate 2 No 1 Yes 2 No 1 Yes of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 5 Pending investigation Division death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P18586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene St. Balto, MD 21201 22 Gandhi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Registrar

DHMH 17 Rev 1/2001

2006

		•	For State Registrar	State of Ma	aryland		artment of rtificate of			ntal Hy	giene Reg. No	/ 11	06	1540	5
	Division		1. Decedent's Name (First, Middle, Las	it)					2.	Date of De	aath Da	v	Year	3. Time of Deat	
	Physici /Medic		Wilma H. Con	nell						May	12,	2000		11:30 A	/M
1	Examin		4a. Facility Name (If not institution, give				4b. City, Town,		of Death			. County o			
			Shady Grove Adve				Rockv		-0411			lontgo			
П	Funeral		5. Social Security Number 6. S	ex 7.Ag □M 2DXF		as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		Min. 8.	Date of Bi	rth a <i>y, Year)</i>	010	Cou		sign
	Director	}	217-42-2462 Usual Residence of Decedent		94	113.			F	April 2	2/, 1	912	Iov	va	_
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	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic O	rigin? (Specif	y Yes or No	0-		- Amen	can Indian,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "naturel", or iteme 23s or 28s-f show other treumatic event, it's Medical Examinating the multified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🛣 No			an, 6(0.)		Specify:		nite	
5-0	72 h	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	dent's Usual Occu	e <i>durina</i> mo	st of working		16b. K	and of Bus	iness/In	dustry	
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	s the	y P	Part II. Other significant conditions of	ontributing to death b	ut not resu	Iting in the u	inderlying cause g	jiven in Part	l.	23e. Did	tobacco	use contrib	bute to t	he cause of death?	
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Division	after Direction by	ertif	4 Homicide determined	building, et	c. (Specify,)	reet, ractory, office	B	201	City or To			or mare	ar modite maniber,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification;	29a. Certifier 1 Certifying Ph (Check only one)	eysician: To the best niner: On the basis o and manner st	f examinati	vledge, deat ion and/or in	h occurred at the vestigation, in my	time, date a opinion, de	and place, and path occurred	due to the	cause(s , date and) and man d place, ar	ner as s	tated. the cause(s)	
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	/Medic Examin	-	4a. Facility Name (If n Johns Hop			number)				ty, Town, o		n of Death			c. County of I	Death	1
634	Funeral Director		5. Social Security Nun 216–36–395		Sex 1∰M 2□F		64 (In yrs.	last birthda Yrs	Month	der 1 Year Days	If Und Hours	er 24 Hrs. s Min.	8. Date of B (Month, E 03/21/	irth ay, Yea 1942	9. 2 Ma	Coun	lace (State or Foreign try) and
	land ow		Usual Residence of D 10a. State	Decedent 10b. County			10c. Ci	ty, Town or	Location							11	0d. Inside City Limits
	Ba-f sh	ctor		Howard			Col	umbia						T			1 ☐ Yes 2Ñ No
	3e or 2	I Dire	10e. Street and Numb 6206 Iron		iy					Zip Code 045				10g. C	itizen of Wha	t Coun JSA	itry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any follury or other traumatic avant, Ire Medical Examinating multiled at ange.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	d 2∭X Married	12. Was De Armed	ecedent E Forces? s 2 XN Give r Dates:		J.S. 1		cedent of F pecify Cuba 2 1 No			ecify Yes or N Rican, etc.)	lo-	14. Race - Black, \ Specify:	White,	etc.
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e,	1 and 2 Health em 27 i		Revena DeL		/ Wife	e	20b. I	Place of Di	sposition (f	vame of		y	Lumbia,	-	21045 Location - Cit	v or To	wn. State
Baltimore, Maryland 21215-0036	Pages ment of ant: If it ury or o		1 🔀 Burial 2 □ 4 □ Donation 5	Cremation 3	□Removal fro	m State	(cemetery, c	crematory o	r other plac		05/17	7/2006	1	.timore		
Balt	permit. Depertition of the pertition of		21. Signature of Fund	enan Service Lie	ensee			,	22. Name Witzk	and Addre	eral	Home	es, INC	•	• MD	210	45
•	Priysician /Medical Examiner	Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list condition are under the cause. Enter Under Cause (Disease or in that initiated events	inal	a. Arte Due	riosc to (or as a	lerot a consec		enter the m				or respiratory	arrest,			Approximate Interval Between Onset and Death
68760,	eat certificate be executed ettending physician and for use as the burial-transit		resulting in death) La	ast	d.	to (or as a	a consec	quence of):						1			
Division of Vital Records, P.O. Box 6876	Attending Physician: The law requires thet the death certificate be rightly. setor: After this certificate has been signed by the ettending physicis by the funeral director, page 2 should be deteched to use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	nonths?		e birth egnant at	2 Feta	al death	3 Ectopic 5 Other		у				23d. Date o Month		ory Day Year
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al Reco	To the Hospitel or Attending Physician: The law requires that the deat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ette completely filled in by the funeral director, page 2 should be deteched to	Completed		-2									24a. Wa aut per 1 💢 Yes	opsy formed?	prio dea:	r to con th?	psy findings available inpletion of cause of
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ion of	nding Phy ath. r: After thi e funeral o	atlon: T	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investiga	28a. Da (M	te of Injur Ionth, Day		28b. Tim Injui	e of	28c. Injur	ry at		28d. Describe				<u> </u>
Divis	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could no determin	200. 116	ace of Inju	ury - At h	nome, farm,	street, fac	tory, office			28f. Location City or T	(Street a	and Number o	r Rura	l Route Number,
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	Sta Regista		31. Date filed (Ment)	Oay Year		Registra			lose				20166	- C ,]	CALL CALIF	יד ה'	. EID 212()]

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 17,20b per fh 9856 6-26-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No LUUS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Month Year Wilhelmina Catherine Dunlap May 15 2006 11:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Country Gardens Assisted Living Highland Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 9. Birthplace (State or Foreign 1 □ M 2√2 F 92 Yrs. Director 276-10-9827 Ohio Feb. 15,1914 Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits "naturel", or Items 23a or 28e-f ehow ofical Exercises must be notified at Director 1 Yes 2 No Marvland Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12752 Scaggsville Road U.S.A. 20777 Funeral permit. Peges 1 and 2 should be filed within 72 hours after deet Department of Health and Mental Hygiene. Important: If Item 27 ie marked other them. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No Specify: White ģ 3 AWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Schaub Fred Schuab Margaret Headlev ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Brian (Daughter) 13191 Highland Road Highland, Maryland 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 9 2006 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Oakland Cemetery Mingo Junction, Ohio 21. Signalure of Funeral Service Licensee ^{22, Name and Address of Facility} Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Day Year 4□Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has al director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Assisted (w ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural Injury s after dec. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 125205 MAY 15,2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto Md 21204 GBMC

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

6701

32. Registrar's Signature

7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #1& Per Phy G86ertificate of Geath Reg. No. 2 0 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Voar 1710 **Physician** +× Felix Diaz MAY 2006 08 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWARD COUNTY GENERAL HOSP U.S. Howard COLUMBIA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 11,1948 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 57 Cuba 578-64-2333 Director Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Hygiene. Uther then "naturel", or items 23s or 28s-f show ent, the Mudical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Howard Clarksville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21029 7128 Guilford Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ Human Resource Manager Own Business .. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: if item 27 ie marked other th ilury or other treumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Guadalupe Priede Feliz Diaz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7128 Guilford Road Clarksville, MD 21029 Harriet Daiz (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: if ite eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-15-2006 Gate of Heaven Cem. Silver Spring, MD ²², Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A cute cerebral hemorhace **Physician** Fihr disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner A cute myo condial ristarchim hrs-Mo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner Ischemic heart diserse. HTM ettending physicien and for use as the burial-transit that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760. COP SMOKEL use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the e P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 99 dyslip dema 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy certificate 2XNo 1 Yes Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗖 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending investigation after death. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 1 g. Cartifying Physician: To the best of my knowledge, death considered at the time, date and place, and due to the causa(s) and manner as etated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 20a Certifian Medicai completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D38833 MAY, 08, 2006 - Janous 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 TENDAILS Rd CLARILIVILLE MD LEA LAZAR MD 6355

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 7 2006

Conti

32 Registrar's Signature

			1 - State of Maryla Registrer		artment of Hertificate of L			ene 2006	15467
76	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death May 14,	2006 Year	3. Time of Death 4:30 PM M
· ·	/Medic Examin	al	Ruth Irene Darnel1 4a. Facility Name (If not institution, give street and number) 6137 Ford Road		4b. City, Town, or Freder	Location of Death	riay 14,	4c. County of Dea Freder:	th
	Funeral Director			s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1	(ear) 9. Bir	thplace (State or Foreign ountry)
	death with the Maryland ms 23s or 28s-1 show court be collined at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	or 28a	Director	10e. Street and Number	rederi	10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23s		6137 Ford Road		217			USA 14. Race - Ame	rices ladies
36	irs after de	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spi n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black, Whi	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other than "natural; or litems 23a or 28a-1 show armatic event, if a Mulical Exactinat must be rightlined at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired;	luring most of work	ing 10	5b. Kind of Business	/Industry
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and	Mental Mental I	To Be	Clayton Calvin Lenhart				Ellen W		
lary	2 should I and Meni Is marke		19a. Informant's Name/Relationship (Type, Print)			and Number or Rur	al Route Number,	City or Town, State,	
e, ≥	D = C =		Charles R. Darnell Husban 20a. Method of Disposition	Place of Dispo	sition (Name of			MD 21702 Dc. Location - City or	
TOL	Pages nent of h ant: If its ury or o		1 Burial 2 □ Cremation 3 □ Removal from State	ount 0	natory or other place			Frederic	
Balti	permit. Pages 1 an Depertment of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Densite	²²	Name and Addres Keeney and 106 East (d of Facility Basford	l PA Fune	ral Home	21701
k.	Physician		23a Part1 Enter the disease, or complications that caused the de snock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ath. Do not ent	er the mode of dying	g, such as cardiac	-	st,	Approximate Interval Between Onset and Death
200	/Medical Examiner		resulting in death) Due to (or as a conse	equence of):)		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quer es of).					
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8760,	rate be executed thysicien and the burial-transit	dicai Ex	resulting in death) Last Due to (or as a const	equence of):					
9	the the	Medic	IF FEMALE:						
P.O. Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as I	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	equires that on signed bould be deta	þ	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			o the cause of death?
Division of Vital Records,	The law requisete has been page 2 should	Completed	Hypertension Hypertension	1			24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
Vita	Physician: r this certifice ral director, I	Be	25. Was pase referred to medical examples? 1 Yes 2 440 Hospital: 1 Inpatient 2		othe Othe		h Check only one	76	
ion of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	ation: To	1 Yes 2 No 10 1 Inpatient 2 27. Manner of Teath 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury	f 28c. Injury	4 Nuising Ho	28d. Describe how	ce 6 Other (Spe vinjury occurred	icity)
Divis	al or Attending s after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, str	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	vestigation, in my or	oinion, death occur	red at the time, dat	e and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	no	29c. License			d. Date signed (Mon May 15, 2	
_	4			00 Wes		Street	Freder	ick MD 2	1701
10000	Sta Regist		31. Date filed (Month, Pay, Year) MAY 1 7 2006 32. Significants Significants	nature	barte				

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lee Ann Dixon May 21:45 P 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 08-03-1915 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F Hours 91 Director 240-36-9656 South Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No Baltimore MD NA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1133 Myrtle Avenue 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. Peges 1 end 2 should be filed withIn 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: <u>چ</u> 3 XWidowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Schools Maintainance 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Mary Keels Edward Keels 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1133 Myrtle Avenue Baltimore, MD 21201 Terry Keels/Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Importent: If its any injury or of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 05-14-06 Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Preumenia 3 days /Medical Due to (or as a consequence of): Examiner Barrys Urosepsis Sequentially list conditions, 1 my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Thipatient 2 ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D AT 243 8946 May 8, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital BARBOUR M.D. 🌠. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2006 Registrar

		-	For State Registrar	State of Ma	ryland / Del	partment of ertificate of			Reg. No. 2	006	15469
	Physici /Medic		1. Decedent's Name (First, Middle) esse H	Elkins				2. Date of De Month	ath Day	Yeer 2006	3. Time of Death
, A	Examin		4a. Facility Name (If not institution,	ch Traum	e Confo	Bali	or Location of De			nty of Death	N/A
3	Funeral Director		220-23-9344 Usual Residence of Decedent	1 M 2 □ F	17 Yrs.	Months Days	Hours M		1988	Coun	lace (State or Foreign try) MD
	Maryland	tor	10a. State 10b. County	LTIMORE	10c. City, Town or REIS	Location STERSTOWN				10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 9 FOX DEN COUR	Т		10f. Zip Code		136	10g. Citizen o		USA
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 Ie marked other than "naturel; or Items 23a or 28a-f ehow important: If Item 27 Ie marked other than "holdral Examinar must be notified at ance." DOCS.	þ	11. Marital Status 1 💢 Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? ed 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1⊡Yes 2∭XNo	Specify:	(Specify Yes or No erto Rican, etc.)	Spec	lace - America lack, White, e	
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_	1 and 2 sho Health and Iom 27 Iom other traum		19a. Informant's Name/Relationsh ANTONIA ELKINS 20a. Method of Disposition		THER 9 FO	X DEN CO	JRT - RE	Rural Route Numb ISTERSTOW Date	IN, MD	vn, State, Zip 21136 In - City or To	
Baltimore,	permit. Pages Department of Important: If It any injury or c		1 Burial 2 Cremation 4 Dehation 5 Other (St		1	RE HEBREW 22. Name and Add	CEM 05	/16/2006 SOL LEVIN	ISON &	BROS.,	
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P.O. Box 68	law requises that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су			Date of delive Month	ory Day Year
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Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director.	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be ined 28e. Place of Injury ling, etc.	2006 12.3 ury - At home, farm, c. (Specify)	street, factory, office	Yes 2 No	Motor 281. Location (City or To	wn, State)	Mucyl	ancl
	the Hosp in 24 hou the Funel ipletely fil	Medicai	(Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death of		date and place	e, and due to	the cause(s)
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1	3		30. Name and address of person Frank Koenig	R Adams C	onley Sha	e, rilita)	y Center				el
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			For State	State	of Maryland	,	artment of Hertificate of E		nd Me	•	giene Reg. No.	006	15470
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	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of	Death	1101		County of Death	
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41	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la:		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth Cor	nplace (State or Foreign
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	and * ~		Usual Residence of Decedent 10a, State 10b, County		10c, City,	Town or Lo	cation						10d. Inside City Limits
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	ns 2	Funerai	11. Marital Status	12. Was De	cedent Ever in U.S	. 13.	Was Decedent of His f Yes, specify Cubar		in? (Spec	ity Yes or No		4. Race - Amei	
٥	be filed within 72 hours after death with the Maryland at Hygiene. Hygiene Hygiene checket than "natural", or items 23a or 28e-f show other than "natural", or items 23a or 28e-f show event. The Medical Evantrae must be incitied at		1 ☐ Never Married 2X Marr	ied 1 X Yes	2 □ No				Puerto P	lican, etc.)		Black, White	
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Maryiand	2 should be and Mental Is marked of reumatic ev	ဌ	19a. Informant's Name/Relations	hip (Type Print)		19b. Mailir	ng Address (Street a				er City or	Town State 7	in Code)
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100	- 16		23 art1. Enter the disease, or shock, or heart failure. List	complications that	t caused the death.	Do not ent	er the mode of dying	g, such as c	cardiac or	respiratory a	rrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Ad	enocorcin	na ol	- Biliara	Trac	+				Onset and Death
	/Medical		resulting in death)		o (or as a conseque								G MODICALLY
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Вох	death atter	Physician/M	in the past 12 months?		birth 2 Fetal of gnant at time of dea		Ectopic pregnancy Other (specify)					Month	Day Year
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ta	rsicien: The law s certificate has t lirector, page 2 s	Bec	25. Was case referred to medica examiner?					26. Place	of Death	Check only	- '		
<u>~</u>	Physic this ce al dire	To	1 □ Yes 🖈 No	Hospital:	☐Inpatient 2☐E	R/Outpatier	nt 3 DOA Othe	ar: 4 □ Nur	sing Hom	e & Resi	dence 6	□Other (Spec	cify)
Division of Vital Records,	ding Physician: h. After this certific tuneral director,	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pendir		te of Injury on th, Day Year)	28b. Time o Injury	Work			8d. Describe	how injury	occurred	
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\leq	or Attano after death Director:	Certification:	4 Homicide determ	ined 286. Pla	ce of Injury - At hon Iding, etc. (Specify)	ne, tarm, sti	eet, factory, office		2	City or To		Number or Hu	ral Route Number,
_	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely illied in by the funeral director.		29a. Certifier De Certifyir	g Physician: To t	he best of my know	/ledge. deat	h occurred at the tim	e, date and	d place a	nd due to the	cause/s) a	and manner as	stated
	• Ho	edicai	(Check only 2 Medical one)	Examiner: On the	basis of examination	on and/or in	vestigation, in my op	inion, deat	h occurre	d at the time,	date and p	place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifie				29c. License					signed (Month	Day, Year)
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	10		30. Name and address of person	ut a completed or	of doubt (lane)	23а) (Туре,	Print)	1	Δ. Δ	7100	i		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registrar Amend Item #26 Per Verb G855**Centificate of Death** Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Fowler Miriam 5:50 p M 05 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel 5618 West Carrel Drive Churchton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug 31, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1□M 2□F Yrs. 1962 Cuba 212-84-8633 43 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Orlando Florida Orange 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32387 2049 Paprika Drive U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If itam 27 is marked other then "naturs!, or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (S)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ¥XYes 2□No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Cuban White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Financial Accountant Importer/Exporter Grade 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Sanchez Hilda U. Rayon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph B. Sanchez / brother 9880 Gorman Road Laurel, Maryland othert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Fernation 3 □ Removal from State ŏ Department of Important: If any injury or once. 5/17/2006 West Arundel Crem. Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List grily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) squamonscell carcinoma metastatic Physician 10 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death? 21 No 1 Yes Be 26. Place of Death (Check only one) Frother's

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760, Records, P.O. Division of Vital

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenne

29b. Signature and title of certifier

Kathleen Kemmer, M.D. 900 Bestgate Road Suite 300 Annapolis, MD 31. Date filed (Month, Day, Year)

29c. License number

D0059173

29d. Date signed (Month, Day, Year)

May 16, 2006

State Registrar

3. Registrar's Signature MAY 1 7 2006

			For Stete Registrer	State	of Marylar				ealth a	and M		giene Reg. No	06	15	.72
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath		3. Time of	Death
	Physicia		Susan Anne Fe	edak							Month May	Day 16	Year 2006	7:30	АМ
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location of	of Death		4c. Coun	ty of Death	1	
			Montgomery Hospi	ce Casey	House		Ro	ckvi	lle			Mon	tgome	ry	
	Funeral		5. Social Security Number 6	S. Sex	7. Age (In yrs.	last birthday)	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h V. Year)	9. Birthp	lace (State o	r Foreign
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	with t	늅	10e. Street and Number				10f. Zij					10g. Citizen of		ntry?	
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5	Ir. or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ve		1 🗆 Yes	20 No	Specify:			Spec	ity: Whi	te	
0-000-c	tura stura	ed	15. Decedent's	Education		16a. Deced	ient's Usu	al Occupa	ation		1	16b. Kind of I	Business/Inc	dustry	
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7	d with	Completed	12th	Ø	19401 34)	Bi	ochen	nist				NIH-	US Go	vernme	ent
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ary	12 should be filed within 1 h and Mental Hygiene. 7 le marked other than ". Ireumatic event, the Mic.		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	r or Rura	l Route Numbe	r, City or Tow	n, State, Zip	Code)	
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<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Healih and Menth Hygiene. Deportment of Healih and Menth Hygiene. The mortant: If team 27 is marked other than "natural; or Itema 23a or 28a-f show eny injury or other treumatic event, the Mudical Examinar mastice notified at once.		20a. Method of Disposition			Place of Dispo	sition (Na.	me of			ate	20c. Location	- City or To	wn, State	
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month **Physician** Lawrence Franklin Fields 7:30 p.m May 9, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 213-46-4066 62 July 14, 1943 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ehow with Injury or other treumatic event, the Madical Examinar must be excitted at once. 1 Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 18518 Eagles Roost Dr. U.S.A Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 19 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1966 1 ☐ Yes 2 No Specify: Specify: 3 □ Widowed 4 □ Divorced Year or Dates White 1968 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Groundskeeper unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Basil D. Fields Myrtle H. Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 380 Owings Mills, Maryland 21117 **Brother** Mr. Dallas Fields 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/17/2006 Maryland Veterans Cemetery Garrison Forest, Maryland 21. Signatur of Funeral Service Licenses Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** weeks vey ne /Medical Due to (or as a consequence of): Examiner Cancer months Sm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been signe irector, pega 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funerel Director: / completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD MENDHIRATTA Suite esearch 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 7 2006 Goodes Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** May 12, 2006 Theresa R. Fetzer 1:20A /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9304 Lindale Drive Bethesda Montgomery It Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 23, 1930 New Jersey Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs Director 069-24-4847 76 Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits worle itam 27 is marked other than "natural", or itame 23a or 28a-f abov other traumatic avant, the Maulical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Bethesda Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9304 Lindale Drive 20817 United States death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status il Hygiene.

Other than "natural", or ita 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked ofth any link of the traumatic avent, spice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ٥ Charles Bross Sarah Reavy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Caggiano/Daughter 6001 Melvern Drive, Bethesda, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition May 12. 20c. Location - City or Town, State 1 ☐ Burial 2 P Cremation 3 ☐ Removal from State Crematorium, Inc. 2006 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

M00803 Bethesda, Maryland 20814-3501 4 □Donation 5 □ Other (Specify) 21. Signature of Tuneral Service Licenses Wisconsin Avenue 23a. Part1. Enter the disease, or complications that calsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Chronic Obstructive Pulmonary Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examiner death certificate be executed physicien and the burial-transit Due to (or as a consequence ot): Physician/Medical use as ed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☒No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۾ page 2 should be Congestive Heart Disease 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 No 1 Yes 2 No Be tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 \$\frac{\text{X}}{2}\$ Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attanding Injury 1 Naturat 5 Pending efter death. Diractor: Aft М 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Harrison, M.D. 1355 Piccard Drive, #102, Rockville, Maryland

Registrar

State

31. Date filed (Month, Dey, Year)

2006

Box 68760

P.O.

32. Registrar's Signature

06-03240

	Please Type or Print in Black indelible link
Georgie	State of Maryland / Department of Health and Mental Hygiene
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Justice Thaddeus		Seorgie I- For State	State	of Maryland	Departm <i>Certific</i>			nd Me	ntal Hy	giene			
Physician		Registrar 1. Decedent's Name (I	First, Middle,Last)	Certific	ale or			т т	2. Date of Deat	g No.	200	3. Time of Death
Medical Examine	er	JUSTICE	THAL	DEUS A	XAIVI	ER (GEORG	31E.	SR.	Month May 13, 20	Day 006	Year	1806 hrs
		4a. Facility Name (if no University of N				41	o. City, Town, Baltimore	or Location	n of Death		4c. C	ounty of Death	110.
Funeral	4	5. Social Security Num			e (In yrs. last bir	thday)	If Under 1 Y	ear If Un	der 24Hrs.	8. Date of Birt	h(MM/DE	/YYYY) 9. Birt	hplace (State or
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Fineral Director: After this certifi To the Fineral Oriector: After this certifi		COLLOCK ONE		an: To the best of m									
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		(AM	of HP	1 1 Dain			0.0	C.M.E.			May 1	4, 2006	
7	-	30. Name and address	s of person who	completed cause of d	leath (Item 23a)								
10		Carol Allan, M	·	nt Medical Exar		Penn S	treet, Balti	more, M	ID 21201				
Sta	_	31. Date filed (Month,	Day, Year)	32. Registra	r's Signature		A				-		
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			1- For Amend Items 25tate of Mandand / Department of Registrar Certificate of	Hoskine/ock	ental Hygie		15476
	Dhysio	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physic /Medi		MARIE V. GERLOUICH		APRIL	21 2006	4:00 PM
	Examir	ner		n, or Location of Death	~~	4c. County of Death	
			CARROLL COUNTY GENERAL HUSPITAL WE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye.	STMINST Par If Under 24 Hrs.	8. Date of Birth	CARRO	
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	/land		10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	Mar Med	tor	MD CARROLL WESTMINS	TER			1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Coun	ntry?
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	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of If Yes, specify Co	of Hispanic Origin? (Spe Juban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 7 Vear or Dates:	No Specify:		Specify:	1150
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f ehow its Madical Examinet mast be notified at	ted	15. Decedent's Education 16a, Decedent's Usual Occ	cupation	166	b. Kind of Business/Ind	17E
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yla	should ind Men s marka umatic	ပ	GROVER PETERSON	MIAU		RUIS	
Maryland	C1 00 08		19a. Informant's Name/Relationship (Type, Print) LINDA D. MEIL - DAUSHTER (015 WOODS		A		
	1 and Health tem 27		20a. Method of Disposition 20b. Place of Disposition (Name of	SIDE DR L	The state of the s	Chocation - City or To	
Baltimore,	ages ant of it: If it y or o		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1 1 1		ARKUILLE	M.N
量	perrait. Pag Dopertment Important: I any injury o		21. Signature / Funeral Service Licensee / 22. Name and Ado		2006 TI		D RD.
ä	Dep- Impo any ii		Kitato Bill h. EVANS FO	UNGRAL DI	/	7	MD 21234
	Prrysician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Approximate Interval Between Onset and Death
-30	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1 /	11/1		
	2	_	Sequentially list conditions, I b. Unjusted FMT b. Supt. (or as a consequence of):	cal woi	end.	NED BY MEDICAL EXPANS	NEK
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury Multiple injuries with	th complic:	ations	WED BY MEDIU	
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8760	icate be executed physician and s the burial-transit	dicail	d		CERTIFIC		
9	tificat ng phy as th	a)					
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of deliver Month	ry Day Year
, P.O	res that thigned by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
rds	quires n sigr ald be	d by	Herresson		1 ☐ Yes	2 No 3 Proba	ably 4 Striknown
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R	The lav	om	Augenterson.		autopsy performed	prior to com	pletion of cause of
ita		BeC	25. Was case referred to medical	26. Place of Death	(Check only one)	NO TO THE	2010
of V	hysic this ce al direc	To	examiner? 1 Ness 2 Hospital: 1 Impatient 2 ER/Outpatient 3 DOA)ther		6 ☐Other (Specify,)
n o	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury		28d. Describe how in		
Sio	ottendi death. ctor: A y the fu	cati	2 Accident investigation 03/10/2005 9:30 a. M	163 2.6110			
Division	itel or At urs after o rel Dirac lled in by	Certification:	4 Homicide determined determined a building etc. (Specify)	6	15"Woodsi	and Number or Rural	minster
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	fedical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in my and manner stated.	y opinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
	To vith	Σ		NO 2 M	29d. [Date signed (Month, D	Pay, Year)
•				NUL '	,	7/21/06	
			30. Name and address of person who completed cause(of death (Item 23a) (Type, Print)	1. Eact H	ain ch	ept 101	with hy
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	(10 27 8) 1 (2147
Į.	Registr		MAY 1 7 2006 Fee 1 1 1 1 1000 1000				·

		-	For Amend Items 25	State of Maryland /	Depa Cer	rtment of H \$55,05/16 tificate of L	ealth and /06dhb <i>Jeath</i>	Mental Hyg	giene Reg. No.2 0 (16 15477
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) WALTER H GLA GLA GLA Aa. Facility Name (If not institution, give st STELLA MARIS			4b. City, Town, or TIMONI		2. Date of Dea Month JANUAR th	Y 25, 20	Year 3. Time of Death 2006 10:15p M f Death LTIMORE
S _a	Funeral Director		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h / Year)	9. Birthpface (State or Foreign Country) PENNSYLVANIA
	the Maryland 28e-f show	Director	10a. State 10b. County BALTIMO	ORE 10c. City, Tov	MON				10g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 ☐ Xo hat Country?
9	be tited within 72 hours after death with the Maryland half Hygiene. ed other than "netural; or items 23a or 28e-f show event, the Madical Examinar must be notified at	Funeral	1 Never Married Married	G ROAD 2. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give WWII Year or Dates:		Vas Decedent of H Yes, specify Cuba	1093 ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		A - American Indian, , White, etc. WHITE
Maryland 21215-0036	within 72 hours ene. than "netural",	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	ation 16a	(Give :	ent's Usual Occup. kind of work done of NOT use retired ENANCE	during most of w l)		16b. Kind of Bus	
ryland 2	e filed Il Hygi other vent, I	To Be Co	17. Father's Name (First, Middle, Last) WALTER S. GLAT 19a. Informant's Name/Relationship (Type)		b. Mailin		MARY I	ame (First, Middle, OBEY Rural Route Numbe		
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta importent: if Item 27 is marked eny injury or other treumatic engine.		FRANCINE SULLEN 20a. Method of Disposition 1 □ Burial 2 【**Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	DER daughter	of Dispos	805 YOR	RK RD.		MD • 2	1152 City or Town, State
Baltir	permit. P Departme importen eny injur		21. Signature of Funeral Service Linense	MACO attions that caused the death. Do		16924	YORK	ROAD, M	IONKTON	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	ral	1	emor	hage		Interval Between Onset and Death
760,	e be executed /sician and e burial-transit	cal Examiner	Sequentiafly list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence			CE	TIFICATION APPROV	ED BY MEDICAL E	
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy			23d. Date Mon	o of delivery th Day Year
	w requires that to been signed by should be detact	by	Part ff. Other significant conditions con	tributing to death but not resulting	-	ndertying cause giv	en in Part I.		_	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Vital Records,		e Completed	25. Was case referred to medical				26. Place of D	24a. Was autor performed 1 Tyes	osy primed? d	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☑ No
Division of V		ation: To B	27. Manner of Death Tarvatural 5 Pending 2 Accident investigation	(Month, Day Year)	Outpatier Time of Injury KNOV	28c. Injur Wor	4/2 (Nursing	Subject	how injury occurre fell	od
Divis	itel or Atte ars after de rei Directo lled in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, At building etc. (Specify)				2525°Pc	Spring	or or Rural Route Number MD Rd., Timonium
	To the Hospitel or Attending Physical 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Medical		ician: To the best of my knowled ler: On the basis of examination a and manner stated.		vestigation, in my o	opinion, death oc se number	curred at the time,	date and place, a	(Month, Day, Year)
	St Regist	ate	30. Name and address of person who co	mpleted cause of death (II m 23a)	a) (Type,		alley	Road	Timaniu	m 21093

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mary 1025 AM 200c Janice Guy 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Taibot Easton Mcmorial Haspital at Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F unk 220-26-4900 76 Oct 18, 1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Caroline Greensboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25548 Hill Road 21639 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Memorial Hospital at Easton 219 South Washington St. Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ②Other (Specify) in state 21. Signature of Funeral Service Licensee
Royald S. Wado Di $^{22.\;Name\ and\ Address\ of\ Facility}$ State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final chronic obspective disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE

Physician /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m eny injury or other traum once.

Physician

/Medical

Examiner

Funeral

Director

or itama 23a or 28a-f ehow other coust be potified at

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"natural"

Baltimore, Maryland 21215-0036

RUICE

The law requires that the death certificate be executed Certification: To within 24 hours after death.

To the Funaral Director: After thi
completely filled in by the tuneral

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Completed

Be

Medical

State Registrar

Records, P.O. Box 68760,

Division of Vital

Hospital or

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schuto shenia

23e. Did tobacco use contribute to the cause of death? 1 es 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed 1□ Yes 2₽No 26. Place of Death Check only one

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending

2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAUL W. Monte 31. Date filed (Month, Day, Year)

2. Registrar's Signature

2195, Washighn

		1	1 - For State Registrar	State of Maryla		artment of H <i>rtificate of I</i>			ene g. No. 2	06	15479
	Physici		1. Decedent's Name (First, Middle, Las	•		GREE	R	2. Date of Death Month	Day	Year	3. Time of Death 2:284 M
	/Medic Examin		4a. Facility Name (If not institution, give			1	Location of Death		4c. County	of Death	J
	Funeral Director		Bon Secours Hospin 5. Social Security Number 6. Security Number 11.		s. last birthday) Yrs.	Baltimor If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 27,		9. Birthpi Coun Mary	lace (State or Foreign try)
	ס		Usual Residence of Decedent					NOV 279	1,720		
	death with the Maryland ome 23a or 28a-f ehow r must be notified at	ž	10a. State 10b. County		City, Town or Lo					11	0d. Inside City Limits 1X Yes 2 □ No
	the M	Funeral Director	MD 10e. Street and Number	Ba	ltimore	10f. Zip Code		1/	g. Citizen of V	What Cours	
	with Sa or	חַב		Street #OC		21216				vitat Court	uy:
	me 2;	nera	740 Poplar Grove	12. Was Decedent Ever in	U.S. 13.		ispanic Origin? (Spe in, Mexican, Puerto	ecity Yes or No-		e - Americ	
2-0030	or its	by Fui	1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	Hican, etc.)	Specify		etc. ack
5	72 hours "naturel", idical Ext	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Bu		
7		Completed	Elementary/Secondary (0·12)	College (1-4or 5+)			during most of worki	,,,9			
7	e filed with at Hygiene. other the		10 r	none	Sa	les Clerk			Retail		
yiand	0 2 0	To Be	Sidney Greer				18. Mother's Name	i (First, Middie, M	alden Suman	Θ)	unk
Mary	2 should and Men ie marke eumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	i Route Number,	City or Town,	State, Zip	Code)
Σ.	and 2 ealth n 27 i		Shazelle Cephas/n		5615	Open Sky	Columbia	, MD 210	144		
more	Page ient o nt: If ry or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Hother (Specify	Removal from State	Place of Dispo	osition (Name of matory or other plac		Date 2	Oc. Location -	City or To	wn, State
מובו	permit. Departm Importe eny inju		21. Signature of Funeral ervice Licen:	see Direct	tor S	2. Name and Addres	omy Board	655 W.	Baltim	ore S	treet
			23a. Part1. Enter the disease, or comp. shock, or heart failure. List only of	olications that caused the dea one cause on each line.	ath. Do not ent	_	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
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ρΩ,	be exicien a	cal Ex	resulting in death) tast	Due to (or as a conse	equence of):						
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C. BOX	w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ry Day Year
7	s that i	by Ph	Part II. Other significant conditions co		4		en in Part I.	23e. Did toba	acco use conti	ibute to th	e cause of death?
cords,	requires that een signed b nould be deta		- SARCON	UTRITION	115-19			1 □ Yes	2 □ No	3 🗌 Proba	ably 4 @Unknown
Ū	sicien: The law re certificate has bee irector, paga 2 sho	Completed	- MALN	UTRITION				24a. Was an autopsy perform	24b. V	Vere autoprior to confleath?	osy lindings available inpletion of cause of
II all	ysicien: is certifica director, p	Bec	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
5	yr sid	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2			er. 4 Nursing Hor)
	nding P uth. r: After I e funera	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe hov	v injury occurr	ed	
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, larm, str	reet, factory, office		281. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	cai	(Check only 2 Medical Exam	ysician: To the best of my kr iner: On the basis of examir and manner stated.	nation and/or in	vestigation, in my or	pinion, death occurre	ed at the time da	e and place a	ind due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	2 10 m		29c. License	e number	29	d. Date signed	(Month, L	Day, Year)
			• -	Duy of	np	D 2	3300		MAY	06	2006
			29b. Signature and title of certifier 30. Name and address of person who of SUDHIR: D 31. Date filed (Month, Day, Year) MAY 1 7 2006	completed cause of death (Ite	em 23a) (Type, こと	Print) 130N	SECON ALTU S	RS HOS	272 1	MD	. 21223
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) MAY 1 7 2006	32. Registrar's Sign	Acut	٧					

			For State	State of Ma		d / Depa	artment	t of H	ealth a		_	_	106	151.80
			Registrar 1. Decedent's Name (First, Middle, Last	*1		Cei	tificate	e or L	Jeath	ŀ	2. Date of Dea	leg. No	200	3. Time of Death
	Physici			oloskon	/						Month	Day	Year ZND6	12:39 PM
	/Medio Examin		4a Facility Name (If not institution, give				4b. City,	Town, or	Location o			4c. Count	ty of Death	20 0
			5. Social Security Number 6. Se	7. Aq	e (In vrs. I	ast birthday)	If Under	1 Year	Under 2	W/7 24 Hrs.	8. Date of Birth	Da	9. Birtho	place (State or Foreign
	Funeral Director			M 2□F	91	Yrs.	Months	Days	Hours	Min.	05/23	/1914	Coun	place (State or Foreign htry) MD
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	a-f sh	ctor	MD BALTIM	ORE		OWING	S MIL	LLS						1 ☐ Yes 2 X No
	with the	Director	10e. Street and Number 85 FENNINGTON CI	DCI F			10f. Zip	Code	2111	7		10g. Citizen of	What Coun	utry? USA
	ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Deced	lent of Hi			cify Yes or No- Rican, etc.)	14. Ra	ace - Americ	can Indian,
36	s after, or ite	by Fur	1 Never Married 2 Married 3 🗖 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 💥 If Yes, Give Year or Dates:	No	į į	1 ☐ Yes 2		Specify:	i, Pueito P	iican, etc.)	Spec	ack, White,	WHITE
9	2 hour	ted b	15. Decedent's Ed	ucation		16a. Deced	dent's Usua	al Occupa	ation	t of working		16b. Kind of I	Business/Inc	
2	ne. hen "n	Completed	(Specify only highest grad	College (1-4or	5+)	HOMEN	kind of wor DO NOT us	e retired)	OF WORKE	g	OWN H	OME	
a 2	filed v Hygie Sther ti	e Co	17. Father's Name (First, Middle, Last)			HOME	IANER		18. Mothe	er's Name	(First, Middle,			
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show afte avant, I'ra Medical Exacili arrival te notified at	To Be	HARRY			BECKE			CAR					MBURGER
Mar	d 2 sho th and 7 le ma traum		19a. Informant's Name/Relationship (7 SANDRA LEVIN / D	ype, Print) AUGHTER			-				Route Numbe			Code)
	s 1 and f Heeli tem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of			ate	20c. Location		own, State
Baltimore,	Page ment o ant: if		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	211		BREW F						BALTI		
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show amportant: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic avant, the Medical Exactle at moral teamorting an once.		21. Sign with 1 F neral Service Licer	Bue			2. Name an 3900				L LEVIN ROAD -			, INC. MD 21208
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications the caused one cause deach li	the death	h. Do not ent	er the mod	e of dyin	g, such as	cardiac o	respiratory ar	rest,		Approximate Interval Between Onset and Death
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	ed sslt	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):								
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8760,		ca	(d	.,									
89 x	certific iding pl	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy		-				23d. D	ate of delive	erv
D. Box	ie death the atter hed for i	by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 4∐Pregnant a 9∐Unknown			⊒Ectopic pr ☐ Other (sp					N	Month	Day Year
, P.O.	uires that the de signed by the a id be detached i	y Ph	Part II. Other significant conditions or	ontributing to death b	out not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco use co	ntribute to ti	he cause of death?
ords	w requires been sign should be										1 🗆 Y	es 2□No	3 🔲 Prob	oably 4 Unknown
Reco	a 0.0	Completed										sy med2	prior to con death?	opsy findings available impletion of cause of
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of <	Physic this ce	은	1 ☐ Yes 2 ☐ No 27. Mann of Death	Hospital: 1 Inpati		ER/Outpatier			707140		ne 5 🗌 Resid			(y)
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<i>y</i>	7		30. Name and address of person who	completed cause of	death (Iten	п 23а) (Туре,	Print)	1/	Sho ando	Mar	40.00	a con	171	2006
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		1. Decedent's Name (First, Middle, La	ast)							2. Date of De	eath Day	Year	3. Time of Death
Physician /Medica		Louis	Freder	ick	Helm					APRI		006	3:54 AM
Examine		4a. Facility Name (If not institution, gi	ve street and num	nber)		4b. City, 1	Town, or	Location o	f Death		4c. County	of Death	
		Washington Coun						stown				hing	
Funeral			Sex 1DXM 2□F	7. Age (In yrs. las	st birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 0ct 12	th ly, Year)	Coun	ace (State or Foreig
Director	- 1	217-03-3130 Usual Residence of Decedent		86	113.					UCT 12	, 1919	Mai	ryland
and	1	10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
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na 23	2	13013 DEVOIDT 00	12. Was Dece	dent Ever in U.S.	13.				gin? (Spe	ecify Yes or No			an Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or itema 23e or 28e-f show may injury or other traumatic event, the Midlest Examination to the rectificate. To Re Commission by Europea Director	Dy ruii	1 Never Married 2 Married 3 XWidowed 4 Divorced	Amed For	rces? 2 No e		f Yes, spec 1 ☐ Yes 2		Specify:	, Puèrto	ecify Yes or No Rican, etc.)	Specify:	c, White,	efc.
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and 2 lealth a m 27 is		Paul C. Helm	Brother		455 F	air M	eado	ws RI	lvd	Hane	rstown	Mary.	land 21740
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permit. Pages 1 s Department of He Important: if Itam any injury or oth	-	21. Signature of Puneral Service Lice	**	. 11111		2. Name and							
Deparmine Department of the police once		* DONA	eau_			.050 Y			NUI	CK TOWS	on runer	al Ho	ome, Inc.
	+	23a. Part1. Enter the disease, or cor shock, or heart failure. List only		aused the death.					cardiac c	r respiratory.	Marylan Marylan	u Z.	Approximate
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseque	ngo (d):	ativ	"E	ai Tu	Ye	CATION APP	ROVED BY MEDICAL	EXAMINA	Approximate Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseque	nce of):	chon.	æp	d in	Tevr	Miles.	ction 19	HI	_
cate be executed physician and the burial-transit	Cal Exe	resulting in death) Last	Due to (or as a conseque	nce of):					9		1	
attending for use as	rnysiciali/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bi	come of pregnand inh 2 Testal d ant at time of dea own	léath 3	Ectopic pre					23d. Date Mon		ry Day Year
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The lar	Completed by								_	24a. Was autoj perfo	psy prmed2 d	ere autor for to con eath?	osy findings available pletion of cause of 2 \square
Physician: The this certificate ral director, pag	מ	25. Was case referred to medical examiner?							of Death	(Check only o	one)		
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To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certific	3 Suicide 6 Could not determine	d 286. Place buildir	of Injury - At homing, etc. (Specify) ing Home		eet, factory,	office		F	28f. Location (City or Tol Broadino	Street and Mumber wn, State) Hog re Assis	erst ted 1	wn, wmy living,
he Hospi in 24 hou he Funer pletely fill	medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the aminer: On the ba and mann	asis of examinatio	edge, deat in and/or in	h occurred a vestigation,	at the tim in my op	ie, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) and mar date and place, a	ner as stand due to	ated. the cause(s)
To T To t	2	29b. Signature and title of continer		(_		number	_		29d. Date signed	(Month, I	Day, Year)
E			4/14/0				000	5222	}		4/14/1	6.	
(1)		30. Name and address of person who	ARUM, M	e of death (Item 2	23a) (Type,	Print) ILL ST	LCC	T, +	taco	25TOW	4/14/1 N, HD 21	740	•
State Registra		31. Date filed (Month, Day, Year)	32. R	egistrar's Signatu	10 21 12 1				•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Harriett A. Harrison 05 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrest Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗗 F 65 Yrs. Director 578-54-5199 12-1-1940 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Owings Mills Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9401 Wordsworth Way # 204 USA 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married African-1 ☐ Yes 2 No 3X Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th 17. Father's Name (First, Middle, Last) CG Brown Ent Admin. Assistant 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Geneva M. Ayers William Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21117 Md 5 Pleasant Ridge Dr.#414, Owings Mills, Angela D.Johnson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Its
any injury or of Wurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Nat'l. 5/16/06 Suitland, Md 22. Name and Address of Facility Wylie F/H PA of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Rd., Randallstown, 23a-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cholangio CAVCON MA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine inding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 11, 2006 (who completed cause of Spath (Item 23a) (Type, Print) 6601 N.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2006

arrison, Harriett

82. Registrar's Signature

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			1 - For State Registrar	State of M	arylan		artmen <i>tificat</i>			and M	ental H	ygier Reg. N	ZUUh	15483	3
ig.	Physici /Medic	al	Decedent's Name (First, Middle, Last) Mary Good1 4a. Facility Name (If not institution, give s				4b. City.	Town, or	Location o	f Death	2. Date of D May	13,	^{0ay} 2006 ^{Yeer}	3. Time of Death 1:30 PM	VI
	Examir	er ~	Kline Hospice H 5. Social Security Number 6. Sex	louse	e (In yrs.	ast birthday)		. Air			8. Date of E		Frederic	k	
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	ath with th	ral Dire	2500 Waterside Dr	ive, Sui	te 10	7	10f. Zip	Code 21701	L			_	Citizen of What Co	untry?	
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e, Mar	and 2 sh lealth and m 27 le m		19a. Informant's Name/Relationship (Typ. Mrs. Barbara L. He			8701	Berw	ick I	nd Numbe Place	Nor	th, Ij	amsv	or Town, State, Z 7ille, MD	21754	
timore	Pages 1 tment of H tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)		C	lace of Dispo emetery, cren thsburg	natory or o	ther place	May 15		ate 6		Location - City or T		
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	15		30. Name and address of person who cor	mpleted cause of d	eath (Item	23a) (Type. I			818				15, 20		_
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May 10 2006	M		Signature and	title of certifier				2							
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Please Type or Print in Black Indelible Ink Matthew Heath, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 8, 2006 Medical Examiner 1345 hrs Matthew Heath Jr. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1415 Carswell Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Director Months Days Hours Min 248-08-9417 Country) 1 M 2X F 49 07-24-1956 SC Usual Residence of Decedent ž. 10a State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show 1 Y Yes 2 No MD NA BALTIMORE Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene anti-I filem 27 is marked other than "natural", or items 23a or 28a-f sht yr other tranmarie event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2806 The Alameda 21239 Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 White, etc. Married 2 X No Yes Yes, Give Year Yes 2 X No specify Widowed 4 Divorced Specify. ş Black or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 Laborer Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Matthew Heath Sr. Martha Woodard 19a. Informant's Name/Relationship (Type, Print) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Heath/ Sister 29 Stratford Place Apt 3J Newark NJ. 07108 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition 20c. Location - City or Town, State or other 1 XBurial 2 Cremation 3 Removal from State crematory or other place) permit Pages
Department of
Important: I Donation 5 Other Specify: Pine Grove 05/13/06 Chester, South Carolina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility La Wylie Funeral Home 638 N. Gilmor Street Balto. MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a Intracerebral Hemorrhage Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED ending physician use as the burial that the death certificate be Box 68760, IF FEMALE 23c. If yet, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> þ 23e. Did tobacco use contribute to the cause of death? ξ 1 Yes 2 No 3 Probably 4 Unknown Chronic alcoholism Records, Completed pinous After this certificate has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? **✓** Yes Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other4 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene ✓ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: the 2 Accident in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 9, 2006 mis 3 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

31. Date filed (Month, L

Day Year

2006

06-02970 Clifford Johnson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certi	ficate of D	eath			eg No. 2		6 1548
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or care		4a. Facility Name (if not institution, Franklin Square Hospita	,			City, Town, or Rosedale	Location of Deat	h	4c. County Baltimo		
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Balt permit Depart Import injury		21. Signature of Funeral Service Lic	ensee		22. Name	e and Address 9 Harfo	of Facility Man	czullo F Baltim	uneral (ore,Mar	Chap vlan	el,P.A.
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		30 Name and address of person wh Ling Li, MD Assistant	o completed cause of de Medical Examiner		^{la)} enn Street, E	Baltimore, I	MD 21201				
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σ.	The law requires that the death certifi are has been signed by the attending page 2 should be detached for use as	by PI	Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the un	derlying c	ause give	n in Part I.		23e. Did t	obacco u	use contribute to	the cause of dea	ath?
rd	quires in sign		Jschen.	2 Card	onyor)cfly					1 🗆 1	Yes 2	ØNo 3□Pr	obably 4 🗆 Un	known
ပ္ပ	law requir as been s 2 should	ojet			, 1	/					24a. Was	ап	24b. Were au	topsy findings av	railable
Re	The la ate ha page 2	Completed									autor perfo	osy rmed/	prior to death?	ompletion of cau	
<u>ta</u>		0	25. Was case referred to medica	1					26 Place of	f Dooth (C	1 Yes	2 No	1 ☐ Yes	2≝No	
≥ :		0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2[☐ ER/Outpatient	3 □ DC	Otho	26. Place of				6 □Other (Spec		
0	g Physe er this eral di	n:T	27. Manner of Death	28a. Date	of Injury	28b. Time of		8c. Injury	at		l. Describe l			:iry)	
<u>ō</u>	Attending Ph or death. ector: After th by the funeral	atio	1 SNatural 5 ☐ Pendir 2 ☐ Accident investi	19	th, Day Year)	lnjury	М	Work′ 1 □ Y	/ es 2 □ No	,					
Division of Vital Records,		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place	of Injury - At I	home, farm, stre	et, factory	, office		28f.	Location (Street an	d Number or Ru	ral Route Numbe	9F,
٥	s after s Direct ed in by	Cer	- Comos	build	ing, etc. (Spec	114)					City or Tov	vn, State	7		
	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyir	ng Physician: To the	best of my kn	owledge, death	occurred	at the time	e, date and p	place, and	due to the	cause(s)	and manner as	stated.	
,	the H in 24 the F iplete	edical	one)	Examiner: On the b	ner stated.	ation and/or inv	estigation,	ın m y opi	mion, death o	occurred	at the time,	date and	place, and due	to the cause(s)	
	To	Σ	29b. Signature and title of certifie	1/			29c	. License					e signed (Month		
•			Fichel /	Newson				04	277	7		May	17. 2	006	
	(h)		30. Namerand address of person	who completed caus	se of death (Ite	m 23a) (Type, F	rint)	, 1	06 4	ND .	7 007	,			
			31. Date filed (Month, Day, Year)	18 18	istrar's Sign	nce Phi	ip Ur	ive C	mey, l	ソ	C08>	<			
	Sta Registr		MAY 1	7 2006 🔏	Jistrat s Sign	B A	order.								

		1 = For State Registrar	State of M	arylan		artment of I			-	giene Reg. No. 2	106	15	488
	<i>*</i>	1. Decedent's Name (First, Middl	e, Last)						2. Date of De Month	ath Day	Year	3. Time o	Death
7787	ician dical	Charles J	efferson						May 15		1041	3:00	рм
April 17 (1982)	niner	4a. Facility Name (If not institution	n, give street and number)			4b. City, Town, o	or Location			,	ty of Death		
"排"。		4047 McDowell	Lane			Lansdow	ne			Balti	more		
Funer	al	5. Social Security Number		je (In yrs. l	ast birthday)	If Under 1 Year Months Days	If Under	24 Hrs.	8. Date of Bir (Month, Da	th		place (State	or Foreign
Direct	or	219-28-0862	t y M 2□F	74	Yrs.	Months Bays	Tiours			23, 1932			
D >		Usual Residence of Decedent 10a. State 10b. County		100 City	/, Town or Lo								ra a transfer
aryla ehov	1			Toc. City	, rown or Lo	ocation						10d. Inside C	2√2 No
198-1	ecto	Maryland Balti	more	Lans	sdowne								-X-110
vith th	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	ntry?	
ath v	Funeral	4047 McDowell L			_	21227				USA			
er de	une	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Spec n, Puerto R	cify Yes or No lican, etc.)	- 14. Ra	ace - Americack, White,		
36 s aft	by F		I Yes Give	[№] 51-5	53	1 ☐ Yes ≱☐ No	Specify:			Speci			
15-0036 In 72 hours after death with the Maryland n "natural", or Items 23e or 28e-f show isciple Exemples must be nealthed at	pa		t's Education		16a Dece	dent's Usual Occur	nation			16b. Kind of I	Whi		
F C 1	Completed	(Specify only highe	st grade completed)		(Give	kind of work done DO NOT use retire	durina mos	t of working	g	TOD. KING OF	305111855/111	dustry	
2121 od within giene.	ü	Elementary/Secondary (0-12)	College (1-4or	5+)		Driver	-/			Undaa		7	
d 2 filed Hygid	Ö	17. Father's Name (First, Middle,	Last)		Dab .	DIIVCI	18. Mothe	er's Name	(First, Middle,	Hudson Maiden Suma		erai	
re, Maryland 212: s 1 and 2 should be filed within the Health and Mental thygiene. Item 27 Is marked other then other traumatic event, In-Min	ToB	Milton Jeffer	son				Cat	theri	ne	Messio	~k		
Maryla d 2 should th and Men t7 is marke traumatic		19a. Informant's Name/Relations			19b. Maili	ng Address (Street						o Code)	
Ma d 2 s lith ar lith ar trau		Kimberly Ford-	daughter			Forest A					,	,,	
s 1 and 3 Health Item 27 other tr		20a. Method of Disposition	dadgireer	20b. Pl	lace of Dispo	esition (Name of matory or other pla	/e., r	Da		21075 20c. Location	- City or To	own, State	
O % 2 = 5		1 ☐ Burial \$ ☐ Cremation 4 ☐ Donation 5 ☐ Other (S					-	11010					
		21. Signature of Fun a Service		Mec		ematory 2. Name and Addre		18/2	2006	Catons	7ille,	, mD	
Balti permit. Departri Imports	Suc	Mima	2.00.1000		Ğ	ary L. Ka 250 Washi	ufman	Fune	eral Ho	ome at 1	MP,	INC.	
100		23a. Part1. Enter the disease, or	complications that caused	the death	Do not ent	250 Washi er the mode of dvir	ngton	Cardiac or	espiratory a	ridge,	MD 2	1075 Approximat	(A
Dhuniais		shock, or heart failure. List Immediate Cause (Final	only one cause on each li	ne.		To			-			Interval Bet Onset and	ween
Physicia /Medic		disease or condition resulting in death)	a. Due to (or as	rare	trace of the	tery	pese	ark				over 1	o yes
Examin	er		Due 10 (01 as	a consequ	بال المانو	00.1					24		
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	Jence of):	cultur	-				Q.	000 10	gre
760, 80 be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Her	post	Dane -							رز رف	0111
exec n an	Exa	resulting in death) Last	Due to (or s	consequ	ience of):						7	10	The state of
8760, sate be expression the buria	<u> </u>		a Her	per	lesse	Denne	سعد				07	ver in	ues
0 0 0		1	1										1
Box 6 sath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7				23d. Da	ate of delive	ary	
Beath death of for	<u>c</u>	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnancy Other (specify)	у			М	onth	Day '	Year
P.O. that the deby the detached	hys	9 Unknown	9□ Unknown										
I Records, P.O. The law requires that the tee has been signed by the page 2 should be detached.	by P	Part II. Other significant condition	ons contributing to death b	ut not resu	ılting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use cor	tribute to th	ne cause of c	leath?
rds quire n sig uld b	D D	Kenal I	unofic	cla	164				1 🗆 Y	es 2 No	3 🗌 Prob	oably 4 🗆	Jnknown
Record he law require has been si	Completed	Reripher	e o Marc	ule	D	uses -	0		24a. Was	an 24b.	Were auto	psy findings	available
Re(he lav	Ĕ								autop		prior to cor death?	mpletion of c	ause of
Vital F sician: Th certificate irector, pag	ပိ	25. Was case referred to medica					00.01		1 Yes	2 No	1 🗆 Yes	2 No	
99=	B	examiner?	Hospital:		ER/Outpatier	t 3 DOA Cth			Check only o				
o		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of	" 3U DOA	4 🗆 140	rsing Home	-	dence 6 Ot		V)	
on of or of	탈	Natural 5 Pendin	9	y Year)	Injury		rk? Yes 2.⊟l			, ,			
Division or Attending after death. Director: Afte	flea	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Inj	ury - At hor	me, farm, str	eet, factory, office			3f. Location (S	Street and Num	ber or Rum	I Route Num	ber.
Div.	Certification:	4 Homicide determ	building, et	c. (Specify,)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tou	n, State)			
Division To the Hospitel or Attentition 24 hours after deall To the Funeral Director: completely filled in by the	a C	29a. Certifier 1 Certifyir	g Physician: To the best	of my knov	wledge, deat!	n occurred at the tir	ne, date an	d place, an	nd due to the	cause(s) and m	anner as s	tated.	
Ho 124 P Fulletely	Medical	(Check only Medical one)	Examiner: On the basis o and manner st	t examınatı	ion and/or in	vestigation, in my o	pinion, dea	th occurred	at the time,	date and place,	and due to	the cause(s)
To the within 2 To the comple	₹ S	29b. Signature and title of certifie	· ^			29c. Licens	e number	Md		29d. Date signe	ed (Month,	Day, Year)	_
- 3 - 0	1	> More	a Wance	n/	WIS	DO	471		/	Mary 1	6 9	001	6
1		30. Name and address of person	who completed cause of o	eath (Item	23a) (Type	Print) 72 4	1 14	0	95707	J.C.	-1	ne 5t	- 22
	0	GORIA DA	mien W	D	2-2) (1)po,	Ball	177	47	111	1 3	100	3 0	
	State	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	เกเด	jeu	mu	ere	porce	1 4	1 1	28	
A. 8/930	istrar	MAY 1	7 2006	6180	J. A	porte							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar		g. No. 211	6 1548
Physicia	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death
edical Exami		James E. Jackson	May 10, 20	006	0040 hrs
7		4a. Facility Name (if not institution, give street and number) Sacred Heart Hospital 4b. City, Town, or Location of Deat Cumberland	in	4c. County of Death Allegany	
<u> </u>		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	rs 8 Date of Birth	n(MM/DD/YYYY) 9. Birt	hnlaco (Stato or
Funeral Director		215-14-6392 1XM 2F 86 Yrs. Months Days Hours Mir	n.	Foreig	
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ž					1 Yes 2 X No
Maryland 28a-f show d at once.	탾	MD Garrett Oakland 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	itry?
h the Mary 3a or 28a otified at	Director	2015 King Wildesen Road 21550		USA	
h with ms 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Ameri	can Indian, Black,
or deat	Full	1 X Yes 2 No	3 7 (1001)		
urs afte tural" imine	ğ	3 Widowed 4 Divorced If Yes, Give Year 140–45 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: whi	
72 hor n "na al Ex	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re	etired)		
5-0036 iled within 72 Hygiene. I other than the M. Ital	Comple	8 none Car Painting		G M	
215-(be filed intal Hygerked other)	Be C		ne (First, Middle, M	,	
212 ould be Ments mark ic ever	10 B	Charles Howard Jackson Rosa F1(19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Orence Ga Rural Route Num	Buer ber, City or Town, State,	Zip Code)
MD d 2 sho lth and n 27 is		Judy Jackson/wife 2015 King Wildesen Ro	d. Oaklar		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Stall and Montha Hygie within 72 hours after death and Monthal Hygie with stall filed by its marked other than "natural", or items 23a or 28a-f Shon or other traumatic event, the M. Mral Examiner must be notified at once		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 X Donation 5 Other Specify:			
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other injury or other traumatic event, the M.		21. Signature of Funeral Service Licensee Rouald S. Wade, Director State Anatomy Boar Baltimore, MD 2120	d 655 W.	Baltimore	Street
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Medical xaminer		Immediate Cause (Final disease a. Cardiovascular Disease Expanguinal)	ion		Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Vascular injury			
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Cathotographics procedures			
pg sq	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours asterdeath. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	X AMENDED 23a, 27 per me g858 8-28-06 vi	/12/07 TT t		
760, ficate be g physicia the buria		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregra		23d. Date of delivery	
Box 68 e death certification attending ed for use as	ician	past 12 months? 4 Pregnant at time of 5 Other (Specify)	naricy	Month E	Pay Year
Bo ne deat the at	Physi	1 Tes 2 No 9 Offiction g Unknown	Too- Bill		
ires that the d signed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive atherosclerotic cardiovascular disease		bacco use contribute to	-
ords, w require is been sig	Completed by	Type out the date out to the date of the d	24a. Was a		topsy findings available
of Vital Records, ng Physician: The law require offer this certificate has been si meral director, page 2 should b	ldu		autops	med? death?	completion of cause of
tal Reco		25. Was case referred to medical 26.Place of Death (Check	1 Yes 2	2 N 1 ✓ Ye	s 2 No
Vital Rec ysician: The his certificate director, page	o Be	examiner?	sing Home 5	Residence 6 Other	
ing Ph After t funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	low injury occurred	
ivision or Attend after death. Director:	atio	2 XAccident 5 Pending 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X Yes 2X No 1 Yes 2X		atheterized	
Division pital or Attendiours after death. eral Director: Affilled in by the fi	ertification:	3 Suicide 6 Could not be determined (Specify) Operative Suite	28f. Location (S or Town, Si	treet and Number or Ru tate) Sacred H	ral Route Number, City eart Hospital
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ပ	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an		e(s) and manner as star	
To th within To th comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	rat trie time, date a	29d. Date signed (Mor	
	=	O.C.M.E.		May 10, 2006	an, Day, rear
		30/Name and address of person who completed cause of death (Item 23a)		•	
		Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
S Regis	tate trar	1/10V 4 12 0000 1 164 1/4 1/4 1/4			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

		•	For State Registrar	State of Ma	aryland		artment rtificate					Reg. No.	006	15490
	Physicia /Medic	an	1. Decedent's Name (First, Middle, ARLENE	JOHNSON	J						2. Date of De Month	Day O	Year O 6	3. Time of Death 8: 15P M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, 1	rown, or	Location o	_	MD		LTIN	PORE
· ·	Funeral Director	8	5. Social Security Number 216 - 42 - 5259	5. Sex 7. Age 7	e (In yrs. la) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	v, Year)		pplace (State or Foreign untry) ID
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	ocation				•			10d. Inside City Limits
	Mary	tor	MD NA		E	Balti	imore							1 X Yes 2 □ No
	ith the	Funeral Director	10e. Street and Number				10f. Zip		207			10g. Citizen o		untry?
	eath w	erai	1007 Tiffany 11. Marital Status	12. Was Decedent	Ever in U.S	i. 13.	Was Deced		201 spanic Ori	igin? (Spe	ocify Yes or No		S • A •	ican Indian,
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if team 27 is marked other than "natural; or tems 23a or 28a-f show mary injury or other traumatic event, Ire Mouleal Examinar must be notiliad a once.	þ	1 Never Married 2 Marrie 3 Widowed 4 ☑ Divorced	Armed Forces?			If Yes, spec 1 ☐ Yes 2		Specify:		ecify Yes or No Rican, etc.)	Spec	lack, White cify:	s, etc. Black
2-0	72 ho 'natur	eted	15. Decedent's (Specify only highest	s Education grade completed)		16a. Dece (Give	edent's Usua e kind of wor DO NOT us	l Occupa k done d	tion <i>uring</i> mos	st of worki	ng	16b. Kind of	Business/I	ndustry
21215-0036	within ene. then	Completed	Elementary/Secondary (0-12) 11th grade	College (1-4or 5	5+)		Domes	_				Pr	ivate	9
<u>م</u> 2	e filed al Hygi other vent, I	BeC	17. Father's Name (First, Middle, L		1						(First, Middle,	, Maiden Sum	ame)	
Maryland	outd b Ments varked	5	Ezekiel Jones					42.		у Јс		0" T		
Mar	d 2 sh th and th sm 7 is m traum		19a. Informant's Name/Relationsh Steven Johnso				-				Balt	-		21230
ē,	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. Pla	NAME OF THE OWNER, WHEN	osition (Name				ate	20c. Locatio		Town, State
imo	Page ment c ant: if ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		I .					/16/	/2006	Arbu	tus,	Md
Baltimore,	Departition Depart		21. Signature of Funeral Service L	March March		1	March 4300	F/1	H We	st	Balt	imore	, Md	21215
	nysician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each li	ne.			,			or respiratory a	rrest,		Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in dealh)	a. R mickl Due to (or as				7						000.43
100	*	ē	Sequentially list conditions,	b. Cerebra	a conseque	arioa aly	a						-	-
D.	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. atrial	fibr	illat	ion							
8760,	cate be executed physician and the burial-transit	icai Ex	resulting in death) Last	Due to (or as	a consequ	ence of):								
9	tificate ig phys as the	e e		d						_				
P.O. Box	that the death certifica led by the attending ph detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	□Ectopic pre □ Other (spe						Date of deli Month	very Day Year
	juires that in signed by ald be deta	þ	Part II. Other significant condition	Ť	out not resu	Iting in the	underlying ca	ause give	n in Part I	l,				the cause of death?
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed	alcohol abuse								24a. Was auto perfo 1 Tes	psy ormed?	b. Were autorior to condeath?	topsy findings available completion of cause of
		BeC	25. Was case referred to medical examiner?	1						e of Death	Check only			
of \	this al di	ု	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatie			7 🗀 140		me 5 Resi 28d. Describe			eify)
O	ig fa	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		y Year)	Injury	M	8c. Injury Work 1 🔲 ۱	:? ∕es 2 🔲		200. 50001150	now injury ood	Juliou	
Division of	F = E -	Certification:	3 Suicide 6 Could n 4 Homicide determi		ury - At hor c. (Specify,	me, farm, s	treet, factory	, office			28f. Location (City or To		mber or Ru	ral Route Number,
	Hospit 4 hour Funera Tely fille	edical C		g Physician: To the best examiner: On the basis o and manner st	f examinati									
	To the within 2 To the complete	Me	29b. Signature and title of certifier					. License				29d. Date sig		
	,_		- Frat M				-	FPI	186	6		05,	09,1	06
	2		30. Name and address of person with the car Bhat, MD	who completed cause of o	s. Cr	23a) (Type	Print) S+ BCL	lhm	ove r	no	21201			
\$	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 7	32 Registr	ar's Signat	ure							·.·.	

			1- For State Registrar Amend #2&290	State of Maryla	ind / Depa 06 _Ji /Ce i	artment of rtificate o	Health and f Death	Mental I	Hygien	C U U U	15491
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	,		URY		2. Date of Month		2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s Anne Arundel Me		r	, ,	o, or Location of De	path		County of Death	
I	Funeral Director			7. Age (In yr. 93	s. last birthday) Yrs.	If Under 1 Ye Months Day		in. (Month	Birth , <i>Day</i> , Year /1912	9. Birth Cor	nplace (State or Foreign untry)
	faryland ehow	ō	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. (City, Town or Lo						10d. Inside City Limits 1 □XYes 2 □ No
	with the N s or 28a-f	Director	10e. Street and Number 34 E. Wheeling St.	reet		10f. Zip Code	21230		10g. Ci	tizen of What Cou	
	er death items 23	Funerai	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13. V		f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or erto Rican, etc.	No-	USA 14. Race - Amer Black, White	
-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 ehow I.a Mudical Examinar must be notified at	کے	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes € No If Yes, Give Year or Dates:		1 □ Yes xx N				Specify:	white
Maryland 21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. ed other than "natural", or items 23s or 28s-1 ehow event, the Mudical Examinat must be notified at	Completed	(Specify only highest grade		(Give	lent's Usual Occ kind of work dor DO NOT use ret Waitres	ne during most of wired)	vorking	16b. K	Serv	,
land;	should be filed of Mental Hygist marked other imatic event,	To Be C	17. Father's Name (First, Middle, Last) Clarence Morgan	V			18. Mother's N	ame (First, Mid	Idle, Maider	n Sumame)	d _a
	nd 2 shoulth and 27 lem		19a. Informant's Name/Relationship (Type Dolores Jory Black				er and Number or				p Code)
altimore,	Page nent o int: If		20a. Method of Disposition 1 ☐ Burial 2 ☑ remation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		sition (Name of natory or other p Cremate	ory 04/1	Date 9.2006		ocation · City or T .timore M	
Balt	permit. Depertraimports ony inju		21. Structure of Funeral Service Licenses	ictor P. Dod	a,Jr. C	Name and Add harles 1 501 E. 1	ress of Facility L. Stever Fort Aver	ns Funer	al Ho	ome, Inc.	230
	Physician	9 7	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the dea						<u> </u>	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Que to (or as a conse	quence of):	HEN	RF FAT	LUNE,	Ac	G.F	10 12Ays
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):	HEAR	T FAR	une	CB	RONIE	40 Ars
8760,	cate be executed ohysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conse	. 001	sidd					Gen
Box 6		lan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-12 in the pas	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel	al death 3 🗌	Ectopic pregnan	су			23d. Date of deliv	- /
э. О	y the	Physician/Me	1 ☐ Yes 2 1 € No 9 ☐ Unknown Part II. Other significant conditions conti	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)				Month	Day Year
Records,	The law requires that the has been signed by age 2 should be detailed.	eted by	Partition Significant Conditions Confi	induing to death but not re	suiting in the un	derlying cause (jiven in Part I.		_	2	the cause of death? bably 4 Unknown
	(Q CL)	Completed							itopsy informed?	prior to co death?	opsy findings available ompletion of cause of 2 No
VIT 2	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: Anpatient 2	7-5-0		44	eath (Check on			
on ot	ding Phys h. After this funeral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inj	4 U Nursing	28d. Describ		6 ☐ Other (Special y occurred	у)
DIVISION	al or Atten after dea I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, stre			28f. Location City or	(Street an Town, State	d Number or Rura)	al Route Number,
	To the Hospital or Attending Ph within 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	ledical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my kn or: On the basis of examin and manner stated.	owledge, death ation and/or inve	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the	ne cause(s) e, date and	and manner as s place, and due to	tated. o the cause(s)
	To the To the Comp	×	29b. Signature and title of pertifier	Selei	Aam	29c. Licer	ise number	3		e signed (Month)	Day, Year)
	(3)		30. Name and address of person who com	pleted duse of death (Ite	m 23a) (Type, P	Print) E	FEWSE 1	HGHW	My A	NN APO	LISMD2140
	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 5 2006	32. Registrar's Sign	ature	,			,		

19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Stuart Knudsen Husband 20a. Method of Disposition 1	P.M Foreign nia Limits P⊠No
Jo Ann B. Knudsen May 14, 2006 2:30	Foreign nia Limits RNO
4016 MacAlpine Court Funeral Director Property of the proper	nia Limits ₽⊠No
S. Social Security Number S. Social Security Number S. Social Security Number To. Size of Birth Months Days Hours Min. Sept. 12, 1924 West Virgi West Virgi Usual Residence of Decedant Toa. State Tob. County Toc. City, Town or Location Toa. State Tob. County Toc. City, Town or Location Toa. State Tob. County Toc. City, Town or Location Toa. State Tob. County Toc. City, Town or Location Toa. State Tob. County Toc. City Town or Location Toa. State Tob. County Toc. City, Town or Location Toa. State Tob. County Toc. City Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Tob. County Town or Location Toa. State Town or Location Toa. State Tob. County Town or Location Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State Town or Location Toa. State T	nia Limits ₽⊠No
Director The color of the co	Limits ₽ ☑ No
10a. State 10b. County 10c. City, Town or Location 10d. Inside City 1 1 1 1 1 1 1 1 1	∑ No
Richard Peyton Bartlett Standard Peyton Bartlett Wilfred Hendrickson	
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Physician //Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): CARD OMY ODATITY Catonsville, MD 21228 Approximation as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): CARD OMY ODATITY	
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Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): CARDIOMONIA Onset and D Onset and D Onset and D	
Due to (or as a consequence of): Examiner CARD COMV DATITY	ath
4) If any loading to immediate	
Cause (Disease or injury that initiated events resulting in death) Last resulting in death) Last	
Description of the control of the co	
Signature of the state of the s	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 21 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Unknown 23d. Date of delivery Month Day Yes 9 Unknown	ar
1 Yes 2 No 9 Unknown 9 Unknown	
> Fait it, Other significant continuous cont	ith?
1 Yes 2 No 3 Probably 4 Ur	kno wn
n of Campleting of Ca	allable se of
performed? death? 1 yes 2 No 1 yes 2 No	
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1 Yes \$\frac{1}{2}\text{No} \text{Individual} 1 Inpatient 2 ER/Outpatient 3 DOA Outlet 4 Nursing Home 5 \text{Nesidence 6 Other (Specify)} \\ \text{27. Manner of Lath 28a. Date of Injury (Month, Day Year) Injury Work?} \text{28d. lescribe how injury occurred Work?} \end{alignment}	
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29a. Certifier 20a. Certifier 20a. Certifier 20a. C	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
The statural state of the state	
J 1 1 1 1 5 1 5 1 0 6	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print). ARVIND DESAIMD 115, Roesly Ro. Glen Burniz	
State 31. Date filed (Month, Pay, Year) 32. Registrar's Signature	Ma

		1 - For State Registrar	State of Ma			artme	nt of H			ntal Hyg		006	15493	
de Discourse to		1. Decedent's Name (First, Middle, Last	1)							Date of Dea Month	th Day	Yea	3. Time of Death	
Physic /Medi			Hattie	E	Kennedy					5	5	2006	7 7 35 AM	
Exami	ner	4a. Facility Name (If not institution, give						Location of D	Death			County of De	eath	
	**	Genesis Homewood 5. Social Security Number 6. Se		a (In ure	last birthday)	Ba1	to er 1 Year	If Under 24	Hrs. o	Date of Birth			inthplace (State or Foreign	
Funeral Director				88	Yrs.	Months			Min.	Date of Birth (Month, Day 8-12-	, Year) -191		N.C.	
yland yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
e Mar e-1 et	ctor	Md	N/A		Balto								¹X Yes 2□No	
death with the Maryland ms 23a or 28a-f ehow r must be notified at	Dire	10e. Street and Number				10f. Z	ip Code			1	0g. Citiz	en of What	Country?	
s 23a	rai	1327 Pentwood Ro		Tues in 11	12.1	Was David	212		2 (04	VN-		S A	nerican Indian,	
If e, INIGITY IGITION INTO TOWNS After death with the Marylan of and 2 should be filled within 72 hours after death with the Marylan of Health and Marial Hyglene. Item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, it a Marylan Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 No No No No No No No No No No No No No			rvas Dece f Yes, spi 1 🗌 Yes		ispanic Origin n, Mexican, P Specify:	Puerto Rica	an, etc.)		Black, Wi Specify:		
2 hou	ted	15. Decedent's Edi (Specify only highest grad	ucation		16a. Deced	ient's Usi	ual Occup	ation during most of	Lwarking	5	16b. Kin	d of Busines	ss/Industry	
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. L	DO NOT	use retired	ibing most of)	i working		ъ.	- .	**	
filed withi Hygiene. other then	Sol	6th grade		N/A		_Dom	estic						Homes	
ylarru buld be fils Mental Hy erked oth	Be	17. Father's Name (First, Middle, Last) Isaiah Edmonds						18. Mother's				Sumame)		
hould d Mer	2	19a. Informant's Name/Relationship (T	vne Print)		19h Mailin	o Addres	s (Straat	Joseph and Number o				Town State	Zin Code l	_
Mary 1d 2 sho lith and lith and lith traum.		Shirley Penn - Da			100,000 (0.00)								, zip code)	
ore, Na is 1 and 2 of Health item 27 I	La	20a. Method of Disposition		20b. I	1327 Place of Dispo cemetery, cren	sition (Na	ame of	L Eoad	Date	o, ma	20c. Loc	ation - City	or Town, State	_
		1 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Mď	Nat Me	mori	al Pa	ark 5-1	12-20	06		rel, M	īd	
그 원칙을 .		21. Signature of Funeral Service Licens		1		-		s of Facility		rch F/		West		
Departing Service Serv		Xala 1	March	~	1			4300	Waba	sh Ave	nue	Ealt	o, Md 21215	
e gar		23a. Pm1. Enter the disease, or comp shock, or heart failure. List only of	lications lost caused ine cause on each lin	the deal	th. Do not ent	er the mo	de of dyin	g, such as car	rdiac or re	spiratory arr	est,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	E	olst.	nexe)	Der	nen	tra					Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as											
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ted sit	niner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conse	mence out									
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ite be ex lysician and he burial	cai		d											
g phy as the			u											
th cert	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Tectonic r	oregnancy				23	3d. Date of d		
deal	sicis	in the past 12 months?	4☐Pregnant at			Other (s						Month	Day Year	
at the day the etache	Phy	9 Unknown												
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rid director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions co	ntributing to death bu	ut not res	culting in the ur	nderlying	cause give	en in Part I.	_		es 2		to the cause of death? Probably 4 Junknown	
law requast been 2 shoul	pleted									24a. Was a		24b. Were	autopsy findings available	
The The ate has page	E									autops perforr	med?	death'		
VICAL ician: ' certifica ector, p	Be C	25. Was case referred to medical examiner? \						26. Place of	Death (C	heck only on			7	
Physic this ce al dire	70	1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatien	t 3 🗆 D	OA Othe	or: 4 Nursii	ng Home	5 🗌 Reside	ence 6	Other (Sp	pecify)	
office Programme	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury		28c. Injun Work	(?		. Describe ho	ow injury	occurred		
Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be	00 - 0141	44 6		М		Yes 2 □ No		1 13 10-				
tal or Al	Certification:	4 Homicide determined	28e. Place of Injubulg	iry - At n c. <i>(Speci</i> i	ome, rarm, str	eet, facto	ry, office		281.	City or Town	reet and n, State)	Number or I	Rural Route Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has: completely filled in by the funaral director, page 2	Medical	29a. Certifier Check only one)	rsician: To the best of iner: On the basis of and manner sta	examina	owledge, death ation and/or inv	occurred estigatio	d at the tim n, in my op	ne, date and p pinion, death o	olace, and occurred a	due to the ca at the time, d	ause(s) a ate and p	and manner place, and di	as stated. ue to the cause(s)	-
Withii To th	Σ	29b. Signature and title of dentifier				29	c. License	number		2	9d. Date	signed (Mo	nth, Day, Year)	
(1/2/2			-M		300	59423	3		Ma	2 11	,2006	
1/2/		30. Name and address of person who c	/ .				,						-	
15					BIVS I			Baltin	nore,	MD	21	239		
∽ St Regist	ate rar	31. Date filed (Month, Day, Yea) MAY 1 7 201	32. Tegistra	urs Signa	de da	ask)	,							

DHMH 17 Rev 1/2001

State

Registrar

Dr. KAVITHA CHEREDDI, M.D.

7 2006

31. Date filed (Month, Day, Year)

MAY

32. Registrar's Signature

HOWARD COUNTY GENERAL HOSPITAL, COLUMBIA, MD

		For State Registrar	State of M	Marylar		artmen rtificate			ınd Mer	ntal Hy	/giene Reg. No.	7000	1549
Division		1. Decedent's Name (First, Middle,	Last)						2.	Date of D	eath Day	y Year	3. Time of Death
Physici /Medio		Elsie	Kadan							May	19,	2006	6:55A
Examir		4a. Facility Name (If not institution,	h	er)		4b. City,	Town, or	Location of	f Death		4c.	County of Dea	
			10 (6	10/2/			No	Stm	in ste	1		Can	* 1
Funeral Director		5. Social Security Number 092-10-2513	5. Sex 7 1 □ M 2 ☐ F	Age (in yrs. 89	. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min. 7	Date of Bi	1 th 91 ² 6	9. Bin New	hplace (State or Foreig Puntary York
pu k		Usuel Residence of Decedent 10a. State 10b. County		10c C	ity. Town or Lo	cation	<u> </u>						10d. Inside City Limits
eho.	5		-011		ampst								1 □Yes 2X No
28a-i	ect	Maryland Cari	. 011	11	ampse	10f. Zip	Code			-	10a Citi	izen of What Co	
filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or items 23a or 28a-f ehow with the Medical Examerer must be notified at	Funeral Directo	2821 Cape Horn	n Road			,	74				, og. on	USA	
dea dea	ne	11. Marital Status	12. Was Decede Armed Force	nt Ever in U s?	J.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Specify , Puerto Ric	y Yes or N	0-	14. Race - Ame Black, Whit	
or it	F	1 Never Married 2 Marrie	d 1 ☐ Yes 2 { If Yes, Give	¹No		1□Yes		Specify:		,			White
ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	s:	1								
"nat	lete	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give	dent's Usua kind of wor	nt done d	ition <i>Juring</i> most	of working		16b. K	ind of Business	Industry
withii then	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+) a	Homen						Dor	mestic	
Hyg other ont,	Be C	17. Father's Name (First, Middle, La	est)						r's Name (F		. Maiden	Sumame)	
lid be lental ked ic ev	To B	Alexander Obud	chowsky					Lena	Bla	nk			
permit. Pages 1 end 2 should be filed within 72 hours atter death with the Marylan Depertment of Health and Mental Hygiene. Importent: it item 27 is marked other then "natural; or items 23a or 28a-f ehow envi fulry or other treumatic event, the Mudical Examples must be notified at Ance.		19a. Informant's Name/Relationshi Lisa Meyers n	iece		19b Maili 2821	ng Address Cap	(Street a	orn	ror Rural R Rd Ha	oute Numb Amps t	er, City,o ead	, Md 21	Zip Code) - 0 7 4
ges 1 er it of Hear it item or othe		20a. Method of Disposition 1	B □Removal from Sta	te Net	Place of Dispo	natory or of	ne of ther place	Cem 5	Date	2006	20c. Lo	cation - City or	Town, State New York
t. Pa tmen tent:		4 Donation 5 Other (Spe		1161									
Depermine Deperm		21. Signature of Funeral Service Li	censee	1_	22	Name an	d Addres	s of Facility	Wy 11	e Fu	nera	I Home	of Balto.
TO E & C		1//////////////////////////////////////										town, r	1d 21133
		23a. Part1. Enter the disease, or c shock, or heart failure. List of	nly one cause on each	ied the dea i line.	tn. Do not en	-			cardiac or re	espiratory a	arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Finat disease or condition resulting in death)	a			DEY	2515	<u> </u>					3 days
/Medical Examiner		,	Due to (or	as a conse	quence of):								1
	5	Sequentially list conditions,	b	as a conse	quence of):								
nsit	ulu u	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	(,,.								
al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or a	as a conse	quence of):								
e be sicie	call	3	d										
ificat g phy as th													
andin use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7F-+:					:	23d. Date of del	ivery
death e ette	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant	at time of		Ectopic pro Other (sp						Month	Day Year
t the by th tache	hys	9 Unknown	9□ Unknown										
as the	by P	Part II. Other significant condition	s contributing to death	but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco u	use contribute to	the cause of death?
en si	ed	Penpi	ners 1	1	2101	101	369			1 🗆	Yes 2	□No 3□Pr	obably 4 Unknown
law re es be 2 sh	Completed									24a. Was		24b. Were au	topsy findings available
The ste h	mo;									perf	ormed?	death?	
ilan: artific ctor,	Be C	25. Was case referred to medical examiner?						26. Place	of Death (C				
nysic nis ce	10	1 Yes 2 ₩0	Hospital: 1 Inpa	atient 2	ER/Outpatier	nt 3□ DO	A Othe	r: 4 ☐ Nur	rsing Home	5 🗆 Res	idence	6 Other (Spe	cify)
ng Pl fter tt nera		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of II (Month, I	njury Day Year)	28b. Time o Injury	2	8c. Injury Work	at ?	28d	I. Describe	how injur	y occurred	
endin eath. or: A he tu	atle	2 Accident investiga				М	1 🗆 1	res 2□N	No				
al or Att efter de i Direct d in by t	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Place of	Injury - At h etc. <i>(Speci</i>	nome, larm, sti fy)	eet, lactory	, office		281.		Street an wn, State	d Number or Ru	iral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the be caminer: On the basis and manner	of examin	owledge, deat ation and/or in	n occurred vestigation,	at the tim in my op	e, date and inion, deat	d place, and h occurred a	due to the	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
o the	Z e	29b. Signature and title of certifier	1 1 1 1	2			License				29d. Dat	te signed (Monti	n, Day, Year)
- s + ō)	Xoun (M2	el	MO		100	0599	943		MI	V16.	20000
//		30. Name and address of person w	no completed cause of	f death /Ite	m 23a) (Tyne						, , 0	1	3
v \		30. Name and address of person w	7 000	tone	AVR.	Sui	72'	307	west	m/m	ster	MO	21187
Sta	ite	31. Date filed (Month, Day, Year)		strar's Sign	ature			- 1		/		7	/
Regist			1		y 4	ack 1							
MH 17 Rev 1/2	001	MAY 1 7	2008	AU	5 19								

ORIGINAL

			1 - For State Registrar	State of M	laryland /		artment of F		nd Mental Hy	/ / / / /	15496
			Decedent's Name (First, Middle	a, Last)	t .		inouto or	Dodin	2. Date of De	Reg. No.	3. Time of Death
	Physici /Medic		ARTHUR	H.	KNOU	ياس	રડ		Month	10 200	/ I I ' / A had M
	Examin		4a. Facility Name (If not institution	, give street and number;)		4b. City, Town, o	r Location of		4c. County of D	
			Ellicott City				Ellicot			How	
	Funeral		5. Social Security Number	152M 2075	ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Bir Min. (Month, Da	th 9.	Birthplace (State or Foreign Country)
	Director		220-03-6540 Usual Residence of Decedent		86	115.			Aug 28		aryland
	/land		10a. State 10b. County		10c. City, To	own or Lo	ocation				10d. Inside City Limits
	Many a-f sh	tor	Maryland Balti	imore		Balt	timore				1 ☐ Yes 2 📉 No
	th the	irec	10e. Street and Number		1		10f. Zip Code			10g. Citizen of What	Country?
	th wil	al	5012 Gateway Te	errace				21227		United	States
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
36	or It	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🔀 If Yes, Give			_	Specify:	,	Specify:	White
8	hour tural	ed b	15. Decedent	Year or Dates:	16	Sa Doco	dent's Usual Occup	ation			
5	within 72 hours after death with the Maryland ene. than "netural", or teme 23s or 28s-f show ta M. dical Exer'ill at Frust be rigilised at	plet	(Specify only highes	it grade completed)		(Give	kind of work done	during most (d)	of working	16b, Kind of Busine	ess/Industry
21215-0036	d with glene. If the	Completed	Elementary/Secondary (0-12)	College (1-4or			ermaker/W			Railr	oad Labor
	e filed al Hygli s other vent, L	Bec	17. Father's Name (First, Middle, I	Last)				_	s Name (First, Middle		
lai	should be nd Mental markad umatic ev	To E	James Knowles			_		Thelm	na Jones		
Maryland	2 sho and le me sume		19a. Informant's Name/Relationsh						or Rural Route Number		
	and lealth m 27 her tr		Loretta J. Wilk	cerson - daug				The second second	Road, Elli		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 le marked other than "netural", or Iteme 23a or 28a-f show amportant: If item 27 le marked other than "netural", or Iteme 23a or 28a-f show any figury or other traumatic event, It a Maralical Exactlist and the rotified all once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from State		of Dispo tery, crei	sition (Name of natory or other plac	:ө) М	lay Date 15,	20c. Location - City	or Town, State
Ē	t. Pa rtmen rtant:		Donation 5 Other (Sp		Loudo		ark Cemet		2006	Balt	imore, MD
Ba	permit. Departr Imports any inju		21. Si natule of Funeral Service	licensee					Hubbard Fu		•
		_	23a. Part1. Enter the disease, or	complications that cause	d the death. De						cyland 21229 Approximate
a	Dhusisian		shock, or heart failure. List of Immediate Cause (Final	only one cause on each li	ine.		och	9, 55511 45 55	ardias of respiratory an	11631,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequenc		- Cae				
	Examiner			SER	515	0 01).					
L.	D #	ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	Due to (or as	a eunsequene	e offi.			0 ! =		
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Send	ome	n Bi	ZANSO	7	COLIT	15	
8760,	cate be executed bhysician and the burial-transit	ũ	resolving in deathy cast	Due to (or as	a consequenc	e of):	LIRE				
87	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		d. 1 EN2	AL F	71	CURE				
9 X	death certifical attending phase as the	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
o.	that the de ed by the detached	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			, (-,,)				
<u>ر</u> ص	es that igned k	by PI	Part II. Other significant condition	ns contributing to death b	out not resulting	in the ur	nderlying cause give			obacco use contribute	to the cause of death?
Records,	w require been sig should b	edt	Chronic of	structure	14	lm	074VG	Dise	<u>a</u> 101	res 2□No 3□	Probably 4 Junknown
900	law requass been 2 should	piet					}		24a. Was	an 24b. Were	autopsy findings available
ž		Completed								rmed? death	o completion of cause of ? es 2☑No
Vital	sian: artifica ctor. I	Bec	25. Was case referred to medical examiner?					26. Place	f Death (Check only o		00 20110
<u>></u>	hysic this co	2	1 ☐ Yes 2 Z No	Hospital: 1 Inpatie		Outpatien	t 3 DOA Othe	ar: 4 Nursi	ing Home 5□ Resid	lence 6 Other (S	pecify)
u	ing P	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b.	Time of Injury	28c. Injury Work			now injury occurred	
Sio	teat tor: the	cat	2 Accident investig	ot be				Yes 2 □ No			
Division of	I or Attendate death Diractor:	Certification:	4 Homicide determin		c. (Specify)	tarm, stre	eet, factory, office		28t. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
_	Hospitel 24 hours a Funerel I stely filled		29a. Certifier 1 Certifying	Physicien: To the best	of my knowled	a. death	Occurred at the time	ne date and	place, and due to the	Sauco(c) and	as stated
	To the Hospitel or Al within 24 hours after of To the Funerel Dirac completely filled in by	edical	(Check only 2 Medicel E	xeminer: On the basis of and manner sta	t examination a	ind/or inv	estigation, in my or	inion, death	occurred at the time,	date and place, and d	ue to the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	100/1	/ Mr	2	29c. License	number		29d. Date signed (Mo	nth, Day, Year)
			> Kro	HUUN/	1 1 1		DS	398	7 1	nay 11.	2006.
10	-1		30. Name and address of person w	vho completed cause of d	eath (Item 23a) (Type, I	Print) KEN	NET	W GE	H, and	
12			300 ARMORY	pr, stul	£ 39	B	JeTin	VR9	- MD 2	1501-	
	Star Registra		31. Date filed (Month, Day, Year)	S 32. Hegistr	ar's Signature	and.					

06-03201 Victoria Lewis

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

•		1- For State Registrar					Certific	ate of	Deat	th				Reg. No		JU	0 1	CHC
Physicia		1 Decedent's Nan	ne (First, Midd	le,Last)							-		Date of D	eath			3. Time of D)eath
edical Exami		VICTORIA	A MARI	E LE	WIS							7	Month May 12,	2006	Yea	r	0825 h	rs
The state of the s		4a. Facility Name	(if not institution	on, give stree	et and nu	ımber)		4	b. City,	Town, or Lo	ocation of		, , ,		c County o	of Death		
E.		Frederick N							Frede	erick					rederic	<		
Euporal		5. Social Security	Number	6. Sex		7. Age (In	yrs. last bir	thday)	If Und	ler 1 Year	If Under	24Hrs.	8. Date of	Birth (MM	/DD/YYYY	9. Birtl	hplace (State	e or
Funeral Director		570-53-8			v		8	,	Month		Hours	Min.	May			Foreign	n	,
Director		370-33-6	0341	1M	2 A F	3	0	Yrs.	<u> </u>				May	21,	1907	Cou	_{intry)} CA	
_		Usual Residence		_		110											15.1	000 110 11
* and		10a. State	10b. County	_		100	City, Town		n								10d. Inside	·—
nd shov	5	MD	Anne	Arun	del		Laur	eı									1 Yes	2 X X No
ne Maryland or 28a-f show any fied at once.	Š	10e. Street and No	umber						10f. Zip	o Code				10g. Cit	izen of Wh	at Coun	try?	
death with the Maryland or items 23a or 28a-f shomust be notified at once.	Director	7903 Ori	ion Cir	cle :	#350	-I			2	0724				U.	S.A.			
eath with the items 23a ast be noti		11. Marital Status		12.1	Was Dec	edent Eve	in U.S.	13. Was	Decede	ent of Hispa	anıc Origii	n? (Spec	ify Yes or	No-	14. Race	- Americ	an Indian, B	Black,
ath v	Funeral	1 X Never Marr	ried 2 M	larried	Armed F			If Ye	s, speci	fy Cuban, I	Mexican,	Puerto Ri	can, etc.)		White	, etc.		
er de		3 Widowed	4 Div	vorced If Yes	Yes Give Yes	2 <u>X</u>	No	1	Yes 2	X No	specify:				Specify:	T ₄ 7h	ite	
rs afi ural'	ğ	15. Decedent's E		or Da	ites:		ed) 16a.			Occupatio		ind of wor	k done	16b.	Kind of Bu			
hou "nat	ted	Elementary/Sec				1-4 or 5+)				rking life. D				1			,	
5-0036 yel within 72 hours after death with the Maryland lygione of the Maryland other than "matural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Completed	Grade 12			yeege (,		Manic	uri	ct				l R	eauty	, Ga	lon	
with with her t	E	17. Father's Name		Last\				Manie	ull		R Mother's	Namo (F	irst Middle		Surname)		1011	
filed filed doct			,															
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	Be	Michael 19a. Informant's N		11-1-11-1	Drint \		10	h Mailina	Addras	- 1 - 1			Ann		City or Town	- 64-1-	7 - O- d-)	_
ID 2121: should be fill and Mental I: 7 is marked natic event,	유									•					•			774
e, MD I and 2 sho Health and fitem 27 is		Linda Jo		εσταρε:	rg /								−⊥ L				and 20	1/24
Fe, f Heg f Tite		20a. Method of Di	Sposition XXCrematio	n 3 R	emoval fr		20b. Place crema	tory or oth			etery,	L	Jale	200.	Location -	City or	Town, State	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of SH ealth and Montal Hygiewith Titlem 27 is marked other than "natural", injury or other transmatic event, the Medical Examiner.	i		5 Other S		ornovar n		West	Arund	lel	Crema	torv	5/	17/20	06	Oden	ton	, Mary	land
nit I artm oorta rry o		21. Schatture of F			,					Address c								
inji inji Dep		Lucia	Mas	alde	lla	/ M00	160	313	ia⊥u ≀ Ta	lbott	Ave	al n	Jaur	P.A. el.	Maryl	and	2070	17
Physician	1	23a. Part I. Enter		r complicatio	ons that c			ot enter the	e mode	of dying, su	uch as ca	rdiac or re	espiratory a	arrest, sh	ock, or hea	rt	Approxima	ate Interval
/Medical			nly one cause	C-		o and f	entany	1 into	wi co	trion						13		Onset and eath
xaminer		Immediate Cause or condition result				a conseque		т шис	миа	CIOII								
merch .		Oti-lle-list-		b.	,	•	,											
R 1	ē	Sequentially list of if any, leading to it	immediate		o (or as a	a conseque	nce of):											
	Ē	cause. Enter Und (Disease or injury		C														
ed sat	Examiner	events resulting in	n death) Last		o (or as a	a conseque	nce of):											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death for the Thours after death for the Thours after death completely filled in by the funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		X UNPENDE	D.	¬ d	ENDED	item#2	23a,27,	28a-f	nerM	E 0856	6/16/	/2006	TT					
760, cate be ex physician he burial	n/Medical								perm	1,6000	,0/10/	2000	11					
8760, tificate be ng physici as the buri	/M	IF FEMALE; 23b. Was deceden	nt pregnant in t		c. If yes, Live I		f pregnancy		ol do oth	3	Ectonic	pregnand	47	23	d. Date of Month		ay	Year
certi certi mdin 1Se as	ciar	past 12 month	ns?	4		nant at time		Fet	er (Spe		Letopic	pregnanc	y		MONG	D	зу	Teal
Box 68 e death cert the attendir	ysi	1 Yes 2	No 9 🗸 Ur		Unkn	iown		5 Otti	el (ope	ich y)								
O. B. It the de by the	Physicia	Part II. Other sign	nificant condi	tions conti	ributing t	o death but	not resultir	ng in the ur	nderlyin	g cause giv	ven in Par	t I.	23e. Did	tobacco	use contri	bute to t	he cause of	death?
t, P.O ires that to signed by	by												1 1	es 2	/ No 3	Proba	ably 4 l	Unknown
S, quire en sig	Completed	. —										_	24a. Wa	e an	■ 24h V	Vere aut	opsy finding	s available
cords, law requir has been s	ple												aut	opsy	р	rior to co	ompletion of	
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should be	E O	n											1 Yes	formed?		eath?	s 2	No
tal Rection: The certificate ector, page		25. Was case refe	erred to medica	al						26.Place of	of Death (Check on	y one)			LE-J		
Vita vsicia his ce direct) Be	examiner?	2 No	Hospit	al: 1	Inpatient	2 🗸 ER/C	Outpatient	3 1	DOA O	other4	Nursing I	Home 5	Resid	ence 6	Other		
n of Vi ling Physi After this funeral did	: To	27. Manner of Dea		2	8a. Date	of Injury	28b.	Time of In	ijury	28c. Injury	at Work?	2 28	3d. Describ	e how in	jury occurre	ed		
on (ion	1 Natural	5 Per	nding	_ ` .	h, Day,Year) 5 /1 	776 E-	4 7.22		1 Ye	es 2 🛚	No 1	nk					
ivisior or Attenc after death Director:	cat	2 Accident	Inve	estigation 🔔		5/12/20	- At home, f	d 7:32					26.1	Street	and Numbe	or Dur	al Route Nu	mber City
Division tal or Attendir safter death	Certification:	3 Suicide		ild not be	(Specify)	**		GIII, DII OO	.,	y, omeo ba	manig, oto		or Town	, State)	23345	Frede	erick Ro	oad
Divisior Hospital or Attend 24 hours after death Funeral Director:		4 Homicide 29a Certifier	7	- 1														
To the Hospital within 24 hours. To the Funeral completely filled	Medical	(Check only	Certifying F Medical Ex	Physician: T aminer:Ont	to the be	st of my kn	owledge, de ition and/or	eath occurr	ed at th	e time, date	e and place	ce, and du curred at t	ue to the ca	iuse(s) a te and ol	nd manner ace land d	as starte	ed cause/e\	
To the within To the comple	edi	_		and	manner:	stated.	alon anaron						10 (11110), 44					
	Σ	29b Signature an	nd title of certif	ier (1/	0.0			29	c. License							th, Day, Year	7)
		May.	te Il	neU	live	ll				O.C.M	1.E.			Ma	y 13, 20	06		
		30 Name and de	dress of perso	n who compl	leted cau	use of death	(Item 23a)			-								
V.		Margarita				dical Ex		111 Pe	enn St	reet, Ba	ltimore,	, MD 21	201					
S	tate	31 Date filed (Mo	onth, Day, Year)	32	legistrar's S	ignature	-	-6									
Regis			AY 1 7	2006		alises	J.	4034										
			300		4	1111		/										

DHMH 17 Rev 1/2001 OCME 2006

ORÍGINAL

			For State Registrar		State of M	aryland	_	artment of F <i>tificate of</i>	lealth and M <i>Death</i>	_	giene Reg. No.	006	15498
			1. Decedent's Name	(First, Middle, Last	"					2. Date of De Month		Vone	3. Time of Death
	Physici /Medio		MILDRE	D	R.			LONG		MAY	Day 14,	2006	9:00 P.M
300	Examin		4a. Facility Name (If	not institution, give	street and number)			4b. City, Town, o	r Location of Death			inty of Death	
			4216 BAY	LIS COURT				BEL (CAMP		Н	ARFORD	
	Funeral		5. Social Security Nu			e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th Venel	9. Birthr	place (State or Foreign
	Director		220-14-72	250] M 2[] XF	82	Yrs.	Months Days	Hours Min.	(Month, Da 7/27/1		Coui VT	RGINIA
۰	ס		Usual Residence of							11211		- V - V - V	WINIA_
	ylan how		10a. State	10b. County		10c. City,	Town or Lo	cation				1	10d. tnside City Limits
	death with the Maryland ms 23a or 28a-f show frount be notified at	Director	MD	HARFORD			ABINO	EDON					1 ☐ Yes 2 📉 No
	h the	İre	10e. Street and Num	ber				10f. Zip Code			10g. Citizen	of What Cour	ntry?
	h wit	<u>=</u>	700 WEST	BEL AIR	AVENUE			210	09		US	SA	
	deat ms ms	Funerai	11. Marital Status		12. Was Decedent	Ever in U.S.	. 13. \		dispanic Origin? (Spean, Mexican, Puerto	cify Yes or No	- 14. F	Race - Americ	
0	r Ite		1 Never Marrie	ad 2 Married	Armed Forces? 1 ☐ Yes 2 🔀					Hican, etc.)		Black, White,	etc.
3	hours after tural', or its at Examina	ρ	3 Widowed	4 Divorced	If Yes, Give Year or Dates:			I□Yes 2፟ÄNo	Specify:		Spe	ecify: WF	HITE
7	o 72 hours after death with the Marylan "netural", or Items 23a or 28a-f ehow sidical Examinat he notified at	Completed	(0	15. Decedent's Edu	ucation		16a. Deced	lent's Usuat Occup	ation during most of worki		16b. Kind o	f Business/In	dustry
9500-612	within 7 ene. than "r	ble	Elementary/Secon	fy only highest grad	College (1-4or		life. L	DO NOT use retire	d) most of worki	ng			
7	D C C	NO.	,,		1 YEAR		EXE	CUTIVE S	ECRETARY		BEN	IDIX	
2	be filed tal Hygi d other	Be (17. Father's Name (i	First, Middle, Last)					18. Mother's Name	(First, Middle	Maiden Sun	name)	
yland		ToE	WM. CLYI	DE STROTH	ER				ANNIE	LEACH			
	s 1 end 2 should Health and Men Item 27 is marke other fraumatic		19a. Informant's Na	me/Relationship (T)	ype, Print)		19b. Mailin	g Address (Street	and Number or Rura	l Route Numb	er, City or To	wn, State, Zip	Code)
Ma	end 2 saith a n 27 is		MELODYE A	A. BRUNN/I	DAUGHTER		4216	BAYLIS	COURT BE	LCAMP.	MD 21	017	
ā,	of Heal		20a. Method of Disp			con		sition (Name of natory or other place		Date	20c. Location	on - City or To	own, State
e E	Peges nent of int: If it			☐Cremation 3 ☐F 5 ☐Other (Specify)				CEMETERY	1	8/2006	MOODE	AWN, M	(ID
Ξ	그든분분		21. Signature of Fur	neral Service Licens	600		22	. Name and Addre	ss of Facility THE	JOHNS	ON FINI	EDAL H	OME D A
g	Department Department Important Income		12						RAVEN BLV		VSON, I		286
			23a. Part1. Enter th	e disease, or comp	lications that caused	d the death.			ng, such as cardiac o			20	Approximate Interval Between
	Physician		tmmediate Cause (F	Finat	rie cause on each	70.	/	F	/				Onset and Death
	/Medical		disease or condition resulting in death)	-	a. Due to let as	a conseque	9	170	OR				
	Examiner			- 1		2010	^	A-x	000	15eg	00		
		ē	Sequentially list con if any, leading to im-	ditions, mediate	b. Due to (or as	a conseque	nco of):	64 6 1		1 26.5	- > -	-	
H	d ansit	ᇤ	cause. Enter Under Cause (Disease or i that initiated events	lying njury		6							
,	al-tra	Examin	resulting in death) L	ast	Due to (or as	a conseque	nce ot):						
8/60,	icate be executed physicien and the burial-transit	dlcai			d								
8	ificat g phy as th	•											
ŏ	death certif e attending od for use as	₹	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome						23d.	Date of delive	ery
ă	leath s atte d for	cia	in the past 12 r	months?	1 □ Live birth 4 □ Pregnant a			lEctopic pregnancy Other (specify)	/			Month	Day Year
o.	that the death certifi ed by the attending I detached for use as	Physician/M	9 Unknown	#40	9 Unknown								
Ţ	that		Part II. Other signific	cant conditions co	ntributing to death b	out not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use c	ontribute to th	ne cause of death?
ds	w requires that the s been signed by th : should be detache	d by								10	res 2□No	3 Prob	ably 4 Unknown
ecor	law rec as bee 2 shou	Completed								24a. Was	an 24	h Were auto	psy tindings available
e L	The la ste has page 2	m								autor	rmed?	prior to con death?	mpletion of cause of
Vital		ပိ	25. Was case retern	ed to medical					OC Place of Death	1 Yes	2.50No	1 🗆 Yes	2□ No
	Physician; rthis certific ral director,	00	examiner?		Hospitat:	ent 2 Ef	B/Outpation	t 3 DOA Oth	26. Place of Death			AUGHTE! Other (Specif	R'S RESIDEN
ō	T - 4	. To	27. Manner of Death		28a. Date of Inju (Month, Da		8b. Time of	28c. Injur Wor		28d. Describe f			<i>y)</i>
JIVISION	iding Phy th. : After thi funeral	ig	1 Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	y Year)	Injury		k? Yes 2 □ No				
<u>s</u>	dea dea ctor y the	fica	3 Suicide	6 Could not be determined	28e. Place of tri	ury - At hom	ne, farm, stre	eet, tactory, office		28t. Location (S	Street and Nu	mber or Rura	I Route Number,
5	efter Dire	Certification:	4 🗌 Homicide	determined	building, et	ic. (Specify)		,,		City or Tov	vn, State)		
	spits nours neral	aic	29a. Certifier	Certifying Phy	sician: To the best	of my knowle	edge, death	occurred at the tir	ne, date and place, a	and due to the	cause(s) and	manner as si	tated.
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: Attercompletely filled in by the funer	edicai	(Check only one)	2 Medical Exami	iner: On the basis o and manner st	f examinatio	on and/or inv	estigation, in my o	pinion, death occurr	ed at the time,	date and place	e, and due to	the cause(s)
	To th within Fo th	Me	29b. Signature and	litle of certifier				29c. Licens	e number		29d. Date sig	ned (Month,	Day/Year)
)			1	V b	ULO A	ر	ne	- This	576L	175	5	15	106
	()		30. Name and addre	ess of person who co	ompleted cause of c	death (Item 2	23a) (Type, I	Print	000	1		1	()
	~./		6.W.	EINEL	2 ms	*	951	2 H.	grand	BU	. E	9/40	. nd
	Sta	te	31. Date filed (Monti	h, Day, Year)	32 Registr	ar's Signatu	re						
	Registr	ar	MΔ	Y.1 7 2000	S. Bensus	J. S.	Seas	All I					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 11, 2006 Jonathan D. Lessels **Physician** 11:55 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Deeth Examiner Ellicott City Howard 10040 Waterford Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 X 2 F 079.38.4375 61 Director January 6, 1945 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A. 10040 Waterford Drive Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Ko Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Narried Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry defense industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ filed withi Hygiene. systems engineer Pages 1 and 2 should be filed nent of Health and Mental Hygi tut: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) Be Anna Howell Gordon C. Lessels 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10040 Waterford Drive Ellicott City, Maryland 21042 Ms. Wendy A. Lessels Spouse Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 1 ☐ Murial 2 ☐ Cremation 3 ☐ Removal from State 05/13/2006 Ellicott City, MD St. John's Cemetery 4 □Donation 5 □ Other (Specify) 21. Synature of Funeral Service Licent permit. Slack Funeral Home, P.A MOO533 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cany hophic Clawsul **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and -trans physician ar Due to (or as a consequence of): Physician/Medical as the attending use a IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 signed by the a id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 No 1 ☐ Yes 2 No Division of Vital 1 Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 4 Nursing Home 5 sidence 6 □Other (Specify) 3□ DOA Sich 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending 1 Natural 2 Accident Injury ospital C. 44 hours after dea... 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide To the Funeral Direct
To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🞢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D26621 141) 2006 15 lew ame and address of person who completed cause of death (Item 23a) (Type, Print)
Milles, Gary A. MD 8186 Lark Brown Road; Suite 203 Elkridge, MD 21075 30. Name and address of person 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 1 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene) 15500 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Irving Leo Lupini May 6, 2006 9:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Buckingham's Choice Adamstown Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1X M 2∏ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 165-20-4538 Director 79 10, 1927 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f ahow the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death v 6991 Arbor Drive 21703 Funeral USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Harbor Master Law Enforcement Pages 1 and 2 should be filed w tment of Health and Mental Hygie rant: If item 27 is marked other it jury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augusto Lupini Adele Lupini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Lupini, son 5902 Lawrence Court, Adamstown, Maryland 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/16/2006 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Italian Independent Cemetery Glen Lyon, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home 23a. Part I Enjer the disease, or compli, alons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. M00999 106 East Church Street, Frederick, MD Approximate Interval Betw Onset and Death Immediate cause (Final disease or condition resulting in death) **Physician** End Stage Renal Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to the collate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed after death. burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probebly 4 ☐Unknown COPD 1 Yes 2 □ No Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? hes 2□ No 1 Tyes Be 25. Was case referred to medical 26. Place of Death Check only one) examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -mo D0058726 May 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000D Ventrie Court, Myersville, Maryland 21773 Yvette Warren, MD, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar